SB 8-75-11

DEPARTMENT OF THE ARMY SUPPLY BULLETIN

Army Medical Department Supply Information

Headquarters, Department of the Army, Washington, DC 20310-2300 20 November 2007

Effective until rescinded or superseded

REPORTING ERRORS AND RECOMMENDING IMPROVEMENTS

You can improve this publication. If you find any mistakes, or you know a way to improve it, please let us know. Mail your letter or DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the US Army Medical Materiel Agency, ATTN: MCMR-MMA, Fort Detrick, MD 21702-5001. If you prefer using email, please address it to **usammacrm@amedd.army.mil**.

This Supply Bulletin contains procedural guidance to augment the policies published in the revised *AR 40-61*, *Medical Logistics Policies and Procedures.*

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NOTICE

This is the last issue of the DA SB 8-75 Series to be published for 2007

OVERVIEW

This supply bulletin contains medical materiel management procedures and guidance. It is designed to augment the policies published in the current *AR 40-61, Medical Logistics Policies and Procedures* (28 January 2005). Both *AR 40-61* and *SB 8-75-11* are required to have complete medical logistics polices and procedures explained.

Where and if there is a conflict between the procedures and guidance contained in the *SB 8-75-11* and the *AR 40-61,* **this *SB 8-75-11* will take precedence**.

Due to the dynamic nature of medical logistics, particularly since 11 September 2001, *the SB 8-75-11* will be updated and published each year to keep the procedural guidance current and to facilitate the changes that are necessary in providing timely medical logistics support.

CHAPTER 1. INTRODUCTION

1-1 PURPOSE

This Supply Bulletin (SB) provides procedures and guidance for operating a uniform supply system for all medical logistical units, both Table of Distribution and Allowances (TDA) and Modified Table of Organization and Equipment (MTOE) organizations.

1-2 ABBREVIATIONS

Explanation of abbreviations and terms are contained in the Glossary Section of this Supply Bulletin.

1-3 REQUESTING CLARIFICATION

a. The chain of command will be used to request clarification of the provisions and requirements in this publication.

b. A memorandum will be used when making a clarification request. The memorandum will include the following:

(1) Page and paragraph in question.
(2) Requester's name and Defense Switching Network (DSN) phone number.

c. Each element in the chain of command receiving a clarification request will try to answer it. The clarification request will be sent to the next higher staff element when it cannot be answered. This procedure will assure that available knowledge and skills are used and the quickest possible answer is given. Requests received outside of command channels will be returned through channels.

1-4 REQUESTING DEVIATION AUTHORITY

Deviations from procedures in this SB will be made only with prior approval from Headquarters, U.S. Army Medical Command (USAMEDCOM). The *Defense Finance and Accounting Service - Indianapolis (DFAS-IN) Regulation 37-1* will be used to prepare and process requests for deviation from accounting procedures. Requests for deviation or waivers should explain the need for the waiver, how long it will last, how the waiver will help accomplish the mission, and how the end results will be measured. The request should include an opinion by the USAMEDCOM legal officer.

CHAPTER 2. MEDICAL LOGISTICS SYSTEMS

2-1. FUNCTIONAL PROPONENT

The Assistant Surgeon General for Force Sustainment, in accordance with (IAW) *Army Regulation* (*AR*) *5-22,* is the functional proponent for Medical Logistics. The Office of the Surgeon General (OTSG) Director of Logistics, and the USAMEDCOM Assistant Chief of Staff for Logistics (ACSLOG), serve as the functional proponent representative for medical logistics Information Management/
Information Technologies (IM/IT).

2-2. THE ARMY MEDICAL DEPARTMENT (AMEDD) LOGISTICS SYSTEMS DIVISION

a. The Logistics Systems Division Mission: To provide IM/IT strategic planning, policy, guidance, and oversight for all medical logistics systems, programs, and technology integration.

Logistics System Division Objectives:

(1) Achieve Joint Netcentricity – One medical logistics system in peacetime and war.

(2) Integrate Automated Information Technology (AIT) into everyday business methodologies and processes.

(3) Train the soldier – Incorporate Computer Based Training (CBT) and other eLearning technologies.

b. Log Systems asserts functional proponent responsibilities by ensuring the AMEDD Logistics Automated Systems Migration path is consistent with existing AMEDD IM/IT corporate strategy. The Logistics Systems Division is responsible for facilitating the development of operational requirements for all logistics systems and programs as well as the acquisition strategy to satisfy those requirements. The Division provides executive level oversight of systems integration and life-cycle management to ensure viable medical logistics support is being provided to sustaining base and deployed force logistics elements Army wide.

c. The AMEDD Logistics Systems Division provides guidance to subordinate commands and Military Health Systems (MHS) proponent groups, as well as conceptualizes and implements new and emerging technologies to enhance medical logistics business processes and automated medical logistics systems.

2-3. MEDICAL LOGISTICS INFORMATION MANAGEMENT/ INFORMATION TECHNOLOGIES (IM/IT)

This paragraph applies to medical logistics IM/IT at automated medical logistics operations, medical fixed facilities, division, and corps level units (Echelon II-V). This paragraph is IAW *AR 25-1* and *USAMEDCOM Regulation 25-1*.

a. Medical logistics IM/IT supports supply chain business processes:

(1) Acquisition, accountability, and distribution of materiel and equipment.

(2) Use, maintenance, and repair of facilities supporting the AMEDD medical mission.

b. Army medical fixed facilities and units conducting medical logistics operations will use existing Department of Defense (DoD)/Army standard medical logistics IM/IT.

c. Medical fixed facilities and units conducting medical logistics operations will not use locally developed or procured non-standard medical logistics systems when either a DoD or Standard Army Management Information System is available.

d. Units and supply activities at all levels will promote the use of electronic ordering for all Class VIII transactions through the available and approved Medical Logistics IM/IT. Specifically, the Installation Medical Supply Activities (IMSA) located at the USAMEDCOM fixed facilities will mandate the use of Medical IM/IT to establish electronic ordering with all customers. Hardcopy or manual requisitions will be the exception. The habitual use of electronic ordering will improve efficiency and effectiveness for both peacetime and wartime operations. Ongoing guidance from the USAMEDCOM to the IMSA will establish electronic ordering procedures.

2-4. MEDICAL LOGISTICS INFORMATION SYSTEMS (IS) DESCRIPTIONS

a. The following systems are authorized as standard DoD and Medical Logistics ISs:

(1) Theater Army Medical Management Information System (TAMMIS). TAMMIS is maintained by the:

U. S. Army Medical Information Technology Center
ATTN: Logistics Systems Branch
2710 Howitzer Street, BLDG 2372
Fort Sam Houston, TX 78234

(a) Medical Supply (MEDSUP): Automated and comprehensive inventory management of medical materiel. TAMMIS MEDSUP provides automated support for inventory management functions at deployable medical units. Functions supported include ordering, receiving, storing, accounting for, and issuing medical supplies and equipment. TAMMIS MEDSUP also provides financial transactions through interfaces with Army/DoD financial systems.

(b) TAMMIS Customer Assistance Module (TCAM): TCAM is no longer approved for use. TCAM has been replaced by the Defense Medical Logistics Standard Support (DMLSS) Customer Assistance Module (DCAM) effective 4th quarter FY 2007.

(c) Communications: TAMMIS can relay information between Table of Organization and Equipment (TO&E) units in various ways. The preferred method uses Local Area Networks (LAN). This method relies on the use of the Mobile Subscriber Equipment (MSE) military communications system. Because communications cannot be assured in wartime, units can also pass information by standard telephone lines, Terminal Services Access Controller System, satellite communications, over a stand-alone LAN (without MSE), by Tactical Terminal Adapter, or by external magnetic/electronic media (floppy disks, flash drives, tape, etc.) delivered by courier. All methods preclude re-entering data at the receiving TO&E unit. Examples of transactions and files that are moved include medical logistics Military Standard Requisitioning and Issue Procedures (MILSTRIP) transactions (requisitions, supply status, shipment status, financial transactions, follow-up transactions, requisition modifiers, and cancellation requests). TAMMIS logistics systems also exchange electronic commerce transactions with vendors. The system is designed to utilize all forms of communications available to a unit in garrison and in a deployed environment.

(d) Theater Enterprise Wide Logistics System (TEWLS) will replace TAMMIS in the interim at medical distribution centers and DMLSS will be used in the deployable hospitals. DMLSS Joint Enterprise Wide Logistics is the system of the future that will integrate TEWLS and DMLSS into a MHS enterprise solution.

(2) Defense Medical Logistics Standard Support (DMLSS): DoD migration is to replace TAMMIS (at deployable hospitals). Fixed Facility activities with DMLSS servers will use DMLSS Functionality.

DMLSS functions include:

- Inventory Management (IM)
- Assemblage Management (AM)
- Customer Area Inventory Management (CAIM)
- DMLSS Customer Assistance Module (DCAM)
- CAIM Source of Supply (SOS)

- Customer Support
- Customer Support on the Web (to be eliminated in the DMLSS Oracle version in FY 08)
- Equipment and Technology Management (E&TM)
- Facilities Management (FM)
- Systems Services
- Universal Data Repository (UDR)
- Reporting-Business Objects.

(a) Inventory Management (IM): The IM module provides users with a standardized, integrated management system, which will provide formal accountability and facilitate materiel management and administration. Functions of this module include cataloging, excess reporting, credit card ordering and reconciliation, physical inventory, online and offline ordering, transaction history, location management, and delivery and pick lists. IM will also implement a simple automated quality assurance program covering recalls, suspensions, hazard alerts, destructions, and the safe medical devices act. This module also supports electronic commerce (ANSI X12) requisitioning capabilities as well as the standard MILSTRIP/FEDSTRIP (Federal Standard Requisitioning and Issue Procedures) interfaces and Internet ordering capability.

(b) Assemblage Management (AM): Provides users, logisticians, and commanders with a standardized and integrated management information system to support assemblage management functions. Performance highlights include AM's ability to: build assemblages, establish and maintain assemblage balances, locations, quality control information, order assemblage shortages, transmit files using File Transfer Protocol (FTP), receive and update status, request status follow-up, create reports, track funds, initiate optical, fabrication requests, provide limited inventory management. The AM module of IM allows users to establish assemblage records for standard and non-standard assemblages. Medical Treatment Facility (MTF) Assemblages include: Anthrax/Smallpox Vaccine (YVAC), Anti-Viral (Pandemic Influenza) (YAV1), Antibiotic (Pandemic Influenza) (YABX), Army Emergency First Responder (YAFR), Chemical Patient Treatment (CPTS), Consequence Management Set (YCMS), Reportable Excess (YEXS), Installation Protection Program (YIPP), MNBCDM (YMBC) and Prussion Blue (YBLU). Other local non-standard sets may be recorded in AM as required.

(c) Customer Area Inventory Management (CAIM)/CAIM SOS):

1) CAIM is designed to give all internal customers the ability to manage an individual stockroom or area. CAIM assists the customer in identifying materiel items required in patient care and clinical support; providing an automated tool for requesting materiel items; physical inventory, credit card ordering, credit card reconciliation location management, receipt, and tracking of patient care related materiel to the point of use. CAIM acts as an individual logistics operation allowing users to go directly to a DoD prime vendor or to the Logistics Division.

2) CAIM SOS gives the customer the ability to sell items to other customer areas as well as managing its own inventory. As with CAIM, the CAIM SOS assists the customer in identifying materiel items required in patient care and clinical support. It provides an automated tool for requesting materiel items; performing a physical inventory; location management; receipts; and tracking of patient care related materiel to the point of use. It also gives the user the capability to issue (sell) to its customers. The following are examples of customers able to use CAIM or CAIM SOS:

- Pharmacy
- Central Material Service
- Operating Room
- Department of Pathology/LAB
- Optical Fabrication Lab
- Materiel Distribution Branch.

(d) DMLSS Customer Assistance Module (DCAM): The DMLSS program manager is reprogramming and replacing TCAM with updated software that complies with the DMLSS Common Operating Environment. As with TCAM, DCAM allows remote customers who have no other medical logistics automation to create automated Class VIII requests with minimal hardware requirements (PC or laptop with a network connection). DCAM customers

can connect to the designated DMLSS or TAMMIS site and select files from the DMLSS or TAMMIS database. Once the files are downloaded, the customer can break the connection and use the DMLSS or TAMMIS data to place orders, check status, review the stockage catalog, and research substitutions. Then, customers can reconnect and send the file containing MILSTRIP transactions to the DMLSS or TAMMIS source of supply. New features in DCAM that did not exist in TCAM include secure data transfers using secure File Transfer Protocol (FTP) with TAMMIS and Hyper Text Transfer Protocol (HTTPS) with DMLSS. Also, a DCAM level 2 has been added to allow Class VIII supply support activities, such as brigade medical supply offices (BMSO), to receive and process electronic DCAM requisitions from subordinate customers. DCAM is an approved part of the DMLSS baseline. DCAM will be part of the Theater Medical Information Program (TMIP) Block 2, Release 1 software suite and will be distributed to some units by the Medical Communication for Combat Casualty Care (MC4) deployment teams. Other customers requiring DCAM will request the application from their medical Supply Support Activity (SSA). The SSA will provide the application, assist the customer in setting up the DCAM account on the SSA server and provide training for the customer. Should DCAM problems occur beyond the capability of the medical SSA, contact the MHS Help Desk.

(e) Customer Support: Provides internal customers with the automated capability to research information from commercial and DoD sources and stocked items from the MTF. Manages/transfers New Item Requests electronically through the levels of approving authorities, create Work Requests to the Facility Manager, medical maintenance manager and provides an automated replenishment process for restocking customer supply areas.

(f) Equipment and Technology Management (E&TM):

1) Equipment Management: Enables customers and equipment managers to manage equipment assets from the time a customer starts researching an equipment item to the point at which the equipment is processed for redistribution or disposal. It also enables the logistician to acquire equipment, track inventory, and dispose of assets through an automated and integrated process.

2) Equipment Maintenance: Provides the user with a systematic approach to equipment maintenance, simplifying the maintenance request process and tracking the progress of requested work. The work order system schedules maintenance procedures and facilitates collection of historical maintenance data, which support the equipment management and budgeting processes. A repair parts module interfaces to the supporting supply activity and the work order system.

(g) Facilities Management (FM): The DMLSS automated information system Facility Management Module (DMLSS-FM) provides a powerful Computer-Aided Facility Management tool for standardizing facility management programs throughout the DoD healthcare industry. It provides comprehensive automated management capabilities ranging from scheduled maintenance and project tracking to regulatory compliance and space management.

(h) System Services: This module manages the Supported Customer data and includes DMLSS Communication Manager (DCM), Table Maintenance Utility (TMU),MTF/Org, Funds Management, Point of Contact (POC), User Privilege, End of Period, Record Management and UDR Delta Process.

(i) Universal Data Repository (UDR): Medical Catalog on CD-ROM is an Automated Information System (AIS) developed to address the DoD's needs to automate and standardize medical logistics procedures for MTFs and outlying medical clinics. Specifically, the Medical Catalog on CD-ROM provides an enhanced product research query capability for medical logistics personnel and their customers. The Medical Catalog on CD-ROM enables the user to group equivalent or similar pharmaceutical and medical/surgical (MEDSURG) products, and perform unit of measure price comparisons. The database gives access to detailed, descriptive data and pricing information on pharmaceutical and MEDSURG items that previously could be obtained only through extensive manual search methods. Additionally, then networked application is the backbone of the integrated DMLSS system. The UDR Delta Process is a web-based process that will upload catalog updates to the DMLSS production servers. This assures that all updates for a monthly period are received in a timely manner.

(j) Reporting: Business Objects. This module allows the user to access the DMLSS database and provide managerial information through the use of queries and reports. This powerful business intelligence software can be used to develop daily, monthly and

quarterly reports. While many reports are already preformatted, the module provides the capability to create ad-hoc reports as required.

(3) Theater Enterprise Wide Logistics System (TEWLS): TEWLS is the initiative to migrate the capability for theater level Class VIII Supply Chain Management (SCM) from TAMMIS into a Systems Applications and Products (SAP)-based, enterprise architecture. TEWLS will build upon the SAP Enterprise Resource Planning (ERP) initiative that has been 'live' at the US Army Medical Materiel Agency (USAMMA) since May 2002, and would bring theater Class VIII management into the same system architecture that is used for the production of Army Medical Equipment Sets (MES) and Medical Materiel Sets (MMS). TEWLS will migrate as an Army sponsored initiative into the DMLSS program at some point in the future.

(4) The Medical Logistics Support Web Portal (**https://medlogspt.army.mil**) is developed and maintained by the AMEDD Logistics Systems Division. It is integrated with the Army Knowledge Online (AKO) through the use of the AKO single sign on. Additionally, the AKO Medical Logistics Group Page in the Medical Knowledge Online community is maintained by the division. The web portal is a collaborative environment for information relevant to the medical logistics community regarding policies, missions, current events, conferences, etc., and also to automate certain business practices making their processes more cost-effective. The medical logistics web applications include: the Optical Fabrication Enterprise application; the Environmental Services Application; Command Logistics Review Program (CLRP) application; the Issue Status Review application; the Medical Logistics eHelp portal; and the medical logistics lessons learned application. The portal provides a web-based tool to track and route medical logistics related questions to the proper subject matter experts.

(5) eZ SAVe: Provides a web-based service that uses data synchronization techniques to compare site logistics data to a centralized authoritative database and make recommendations for changes in three categories.

-Opportunities for better product pricing (current product price is higher than "best available")

- Opportunities for better sourcing (an e-Commerce source of supply is available but not being used)

- Opportunities for site record improvement and/or contract coverage improvement (critical product data missing or does not match authoritative data).

b. The following systems are authorized as standard DoD and Army Logistics Management ISs:

(1) Purchase Request Web (PRweb): Web-enabled application between a customer and their servicing contracting office for the processing and acceptance of requirements for local purchase. From their desktop Web browsers, customers can create and route purchase requests, with attachments, to other PRweb users for approval and fund certification. Approved requirements are transmitted directly to the Procurement Desktop-Defense (PD^2) database of the supporting contracting office. PRweb is utilized when TAMMIS or DMLSS is not available or requirements require attachments and extended descriptions.

(2) Defense Blood Bank System (DBBS): The DBBS automates the blood bank operations and is currently fielded to Medical Logistics (MEDLOG) units, deployable and fixed hospitals with a blood bank/donor center support mission. This application will be integrated as part of the TMIP suite of software to support the Forward Support Medical Company (FSMC), Main Support Medical Company (MSMC), MEDLOG units, and deployable hospitals in the corps and Echelons Above Corps (EAC) levels.

(3) Spectacle Request Transmission System (SRTS): SRTS automates the patient record portion of the optical prescription and order transmission process to MEDLOG units and Optical Fabrication Laboratories in the corps and EAC levels.

(4) Global Combat Support System-Army (GCSS-A) Maintenance (MNT): GCSS-A-MNT is the replacement for the Unit Level Logistics System-Ground (ULLS-G) that will be used in all FSMC, Brigade Support Medical Company, MSMC, and Sustainment Support Medical Company at Echelon II and III units. It also replaces the Standard Army Maintenance System Levels 1 and 2 (SAMS-1 and SAMS-2) and the Army Reserve Supply and Maintenance System (ARSAMS) that are used in selected Medical Logistics Companies, Logistics Support

Companies, Medical Brigades, and USAMEDCOM units. ULLS-G, SAMS-1, SAMS-2, and ARSAMS are the migration systems for all MEDLOG units using TAMMIS MEDMAINT, as well as deployable hospitals in Corps and EAC levels. GCSS-A-MNT will be used in all medical units authorized a company or battalion level motor maintenance operation in the division, corps, and EAC levels.

(5) Joint Medical Asset Repository (JMAR): JMAR Asset Visibility is an important decision support database. The vision of JMAR is to provide Global Access to Joint Medical Logistics Information for any user, any time on any government machine. It is recognized by the Department of Defense as the single source to acquire, manage, and provide timely and accurate Joint Medical Asset Visibility Information. JMAR daily receives data from a multitude of government legacy systems including DMLSS and TAMMIS/TEWLS.

JMAR is constantly evolving and currently has report and ad hoc asset query capability for Assemblages, Blood, Facility, Inventory, Prime Vendor (PV), Global Transportation Visibility and Materiel and asset visibility that can be queried.

The JMAR website can be located at: https://jmar.detrick.army.mil/.

In FY08 JMAR will migrate from an operational data store (repository) to a data warehouse allowing users to access detailed supply transaction history. JMAR will have the ability archive greater amounts of data in the new data warehouse.

(6) GCSS-A Property Book Unit Supply Enhancement (PBUSE):

GCSS-A-PBUSE is the replacement for the Unit Level Logistics System S4 Module (ULLS-S4) and Standard Property Book System-Redesigned systems that will be used in all medical units at the battalion level and higher that maintain their own property books in the corps and EAC levels.

c. When standard MTF medical logistics systems do not provide the functionality to support a required medical logistics business practice, non-standard IM/IT are authorized only after approval through the AMEDD Directorate of Logistics/Assistant Chief of Staff for Logistics (DOL/ACSLOG), with final approval authority at AMEDD CIO (Chief Information Officer). MTFs shall submit a request for waiver through their respective Regional Medical Command (RMC) to the:

Commander, USAMEDCOM
ATTN: MCLO-LS
2050 Worth Road, Suite 8
Fort Sam Houston TX 78234-6008

d. Army medical activities and units operating a manual medical accounting system will follow this Supply Bulletin and procedures in *AR 40-61*, *AR 710-2*, and Department of the Army Pamphlet *(DA PAM) 710-2-2*.

e. Army medical fixed facilities are authorized to use commercial automated medication and supply distribution systems, known as Point of Use (POU).

(1) Coordination with USAMEDCOM is required to purchase or lease POU systems in order to apply the numerous system interfaces that maximize the benefits of POU cabinets. Requests to purchase or lease POU systems will be submitted through the respective RMC to:

Commander, USAMEDCOM
ATTN: MCLO-LS
2050 Worth RD, Suite 8
Fort Sam Houston TX 78234-6008

Requesting activities must submit justification that includes projected economic and clinical benefits.

(2) Activities with POU systems will follow prescribed security measures and system requirements for medication management outlined in *AR 190-51*. Activities with POU systems will maintain written policies and procedures for security, accountability, and emergency situations.

f. DMLSS PMO (Program Management Office) intends to field Radio Frequency Identification Devices (RFID) as part of the DMLSS Oracle Tech Refresh (OTR) initially at three identified alpha sites, Ft. Belvoir, Dover AFB, and National Naval Medical Center (NNMC). As part of the OTR deployment, DMLSS will field the initial RFID infrastructure to these three sites. Infrastructure will be determined upon the recommendations gathered from the RFID site surveys. Army medical activities will be responsible to utilize and maintain Radio Frequency Identification devices such as RFID readers, antennas, hand-held terminals, scanners and printers. Trouble calls from AIT equipment in support of DMLSS application will be submitted to the MHS helpdesk IAW procedures described in paragraph 2-5., Help Desk.

2-5. HELP DESK

a. Trouble calls for support of TAMMIS will be submitted to the U.S. Army Medical Information Technology Center (USAMITC), Enterprise Service Desk at 800-872-6482, DSN 421-3300, or 210-295-0799. E-mail help requests may be submitted to usamitc.servicedesk@amedd.army.mil.

b. Trouble calls for support of DMLSS, DCAM or TEWLS will be submitted to the MHS Help Desk at any of the following numbers:

800-600-9332 Continental United States (CONUS)
210-767-5250 (Direct/Commercial)
866-637-8725 Outside CONUS (OCONUS)

Digital Help requests can be made at: **http://www.mhs-helpdesk.com**.

c. Requests for information on TEWLS may be submitted to the TEWLS Competency Center Director at **TEWLSCC@amedd.army.mil**

2-6. SYSTEM CHANGE PROCESS

The System Change Request (SCR) is an official recommendation to correct or enhance the functionality of IS. In a formal process, the SCR is validated and accepted by the USAMEDCOM and the OTSG Logistics Systems Division. Units or activities that have identified a significant problem or possible improvement that may warrant an SCR, will submit their ideas to the appropriate project office and USAMEDCOM through the MHS help-desk.

CHAPTER 3. MEDICAL MATERIEL MANAGEMENT

This Chapter provides the procedures for a Supply Support Activity (SSA) and other supply operation for medical materiel to:
Operate, stock, requisition, issue, dispose of excess,
and measure its operations.

3-1. MEDICAL SUPPLY SUPPORT ACTIVITY (SSA) OPERATIONS

a. The SSAs for medical materiel are distinguished from other medical supply operations in that they:

(1) Operate a stock record account per *AR 710-2*

(2) Perform the full range of supply functions identified for SSAs in *AR 710-2*

(3) Appoint an accountable officer per *AR 735-5*

(4) Requisition materiel directly from the wholesale system or from a major, intermediate level medical materiel SSA.

b. The SSAs for medical materiel include:

(1) Installation Medical Supply Activity (IMSA)

(2) Medical Logistics Battalion (MEDLOG Bn): In peacetime, MEDLOG Bns may perform the full functions of, may have a training mission, or may have an area supply mission. Upon mobilization and/or deployment, the MEDLOG Bn will normally perform all SSA functions.

(3) U.S. Army Medical Materiel Center Europe (USAMMCE)

c. Other supply operations for medical materiel maintain informal stock control records in support of a direct support or area supply mission. These operations do not normally requisition directly from the Defense Logistics Agency (DLA) system and do not perform the full range of supply and Financial Inventory Accounting (FIA) functions.

d. Other supply operations for medical materiel include:

(1) Combat Division level medical supply support provided by the Division Medical Supply Office (DMSO).

(2) Medical supply detachments.

(3) MTOE hospital units with an area supply mission.

(4) Other medical units with an area supply mission.

(5) Medical Logistics Management Center (MLMC). The MLMC is a unique organization that currently has a comprehensive and evolving role in Reach Logistics.

3-2. SUPPLY SUPPORT ACTIVITIES

The SSAs for medical materiel provide direct, general, and/or installation support to units and activities within a designated command or area. The unit's or activity's MTOE, TDA, or Major Command (U.S. Army) (MACOM) directive will state the mission for providing this support. The SSA:

a. Maintains accountability and manages medical supply stocks that are stored for issue to authorized supply customers.

b. Operates a stock record account per *AR 710-2*;

c. Operates with a standard logistics Information System (IS);

d. Conducts prescribed FIA and financial management of the:

(1) Defense Working Capital Fund (DWCF), which finances acquisition of SSA stocks at selected activities.

(2) Army fund, or Operation and Maintenance, Army (OMA) fund.

(3) Defense Health Program (DHP) fund, which finances acquisition and distribution of SSA stocks at selected activities.

e. Establishes an electronic ordering process with all external deployable units/customers.

(1) Electronic ordering implies that a remote connection is established and data is transferred from the customer to the supporting SSA.

(2) All medical SSAs and their supported customers may use only an approved Class VIII IS to accept and transmit requisitions.

(3) The electronic ordering processes will be used during peacetime and wartime operations.

3-3. INSTALLATION MEDICAL SUPPLY ACTIVITY (IMSA)

a. The IMSA is normally the SSA for medical materiel for a designated installation and/or geographical area and is under the control of the Medical Center (MEDCEN) or Medical Department Activity (MEDDAC) commander. The IMSA is normally separate from the installation's consolidated supply operation.

b. The MEDCEN or MEDDAC commander provides medical supply support to designated units and activities on the installation and within the assigned geographical support area (see *AR 5-9*).

c. The Medical Supply Officer (MSO) is responsible to the MEDCEN or MEDDAC commander for operation of the IMSA.

d. The IMSA accountable officer (and/or MSO) directs the operations of the IMSA. The MSO provides total medical supply support to all supported units and activities. The MSO is responsible for security of materiel per *AR 190-51*.

e. The IMSAs are authorized direct contact with customers, the USAMMA, Defense Supply Center Philadelphia (DSCP), other government agencies, supporting medical supply, and local purchase activities on medical supply matters.

f. The USAMEDCOM IMSAs, under the direction of their RMC, will meet with all supported active and U. S. Army Reserve Command (USARC) units at least annually to determine mobilization and deployment requirements.

3-4. MEDICAL LOGISTICS BATTALIONS/U.S. ARMY MEDICAL MATERIEL CENTER EUROPE

a. The MEDLOG Bn/USAMMCE is assigned a medical SSA mission that supports all customers according to the logistics support plan developed for their command or area of operation. The plan outlines the relationship between the MEDLOG Bn/USAMMCE and their supply support. The CONUS MEDLOG Bns supporting command shall coordinate the logistics support plan with the supporting RMC.

b. The MEDLOG Bn supported by an IMSA must conduct all interfaces electronically with the wholesale system (such as, submission of MILSTRIP replenishment requisitions) through the IMSA unless directed by the IMSA/RMC.

3-5. CONSOLIDATED SUPPLY ACTIVITIES ON ARMY MEDICAL DEPARTMENT INSTALLATIONS

a. On Installations under AMEDD control, other supply commodities may be consolidated with medical into a single activity.

b. The AMEDD installation consolidated supply activities:

(1) Operate under a structure similar to that of the IMSA.

(2) Are authorized, by The Surgeon General (TSG), direct contact with nonmedical supply activities, Service Item Control Centers, and National Inventory Control Points (NICPs), as appropriate.

3-6. U.S. ARMY NATIONAL GUARD UNITS

U.S. Property and Fiscal Officers (USPFOs) may provide IMSA-type support to Army National Guard (ARNG) units. The USPFOs and ARNG MTOE units assigned a medical supply support mission will operate per *SB-8-75-10* and this *SB 8-75-11*.

3-7. MEDICAL MATERIEL MANAGEMENT PROCEDURES BY U. S. ARMY RESERVE (USAR) AND ARNG PERSONNEL ASSIGNED A PATIENT-CARE MISSION

a. The USAR and ARNG units may requisition and use controlled, shelf-life refrigerated materiel when they provide patient care to military personnel authorized such care by *AR 40-3*. During use, ARNG and USAR units will control and account for those items according to this chapter, *AR 40-2* and comply with pharmaceutical management procedures in the *SB 8-75 series*.

b. When the patient-care mission has been completed:

(1) The USAR units will coordinate the turn-in of all unused stocks to the supporting IMSA/MEDLOG Bn/USAMMCE.

(2) The ARNG units will:

(a) Return all controlled items per this SB.

(b) Return as directed by the U.S. Property and Fiscal Officer (USPFO) unit of issue quantities of all other items unlikely to be consumed prior to their expiration date. Return these items within 60 days of the completion of the patient care mission.

(c) Return Federal Supply Class (FSC) 6505 items that are on the IMSA/MEDLOG Bn/USAMMCE stockage list and unlikely to be consumed within 12 months.

(d) Manage remaining stocks as specified in applicable regulations and the *SB 8-75 series*.

(e) Account and Report all on hand Medical Chemical Biological Radiological and Nuclear (CBRN) Defense Materiel (MCDM) thru the DoD/Food and Drug Administration (FDA) Shelf Life Extension Program System (SLEP) see chapter 4 of this SB, *SB-8-75-S7 and SB-8-75-S10*.

3-8. STOCKAGE

a. The SSAs identified in this Supply Bulletin, may stock:

(1) Standard items; which are catalogued items listed in the Army Master Data File (AMDF), Federal Logistics Record (FEDLOG) or Universal Data Repository (UDR) Medical Catalog (MEDCAT).

(2) Nonstandard items are items not listed in the above catalogs; however, they are required to support the health-care mission.

b. The MTOE medical supply operations may stock:

(1) Consumable items authorized in the supported Medical Sets, Kits, and Outfits (SKOs).

(2) Consumable items authorized in the resupply module for supported MTOE hospitals.

(3) Items used to meet contingency missions, training requirements, or used to provide garrison medical support, if approved by the command surgeon. These units will maintain command surgeon approved Authorized Stockage Lists (ASLs) that reflect both wartime and peacetime requirements.

c. The ARNG units maintain State Surgeon-approved formularies.

3-9. STOCKAGE CRITERIA

a. The IMSA/MEDLOG Bn/USAMMCE will follow these guidelines when determining stockage.

(1) When six recurring demands have been recorded within a 360-day period, establish an initial stockage for the item.

(2) If less than six recurring demands have been recorded, a customer may request in writing that an item be stocked.

(3) For emergencies, the Unit's senior logistics officer can approve stockage of items.

(4) There must be at least three recorded demands within a 360-day period, to maintain stockage.

*** NOTE: In the event that the item the customer requested to be stocked is no longer required, the customer may be charged for the unused quantities left in stock.**

b. The MTOE medical supply operations will follow these guidelines.

(1) When six recurring demands have been recorded within a 360-day period, establish an initial stockage for the item.

(2) There must be at least three recorded demands within a 360-day period to maintain stockage.

(3) Follow MACOM guidance when establishing stockage criteria for items that support:

- Authorized Stockage List (ASL)
- Mandatory Parts List
- Resupply of medical assemblage components.

3-10. STOCKAGE LISTS

a. Activities with web connectivity may setup connection to DCAM as outline in chapter 2 of this SB; the Medical Stockage List may be downloaded from DMLSS/TAMMIS to DCAM. If the activity has no web connectivity the IMSA/MEDLOG Bn/USAMMCE will provide copies of the stockage list to supported activities. Local policy will govern frequency and recipients.

b. The MTOE medical supply operations must maintain ASLs. Local policy will govern the distribution of the ASLs.

3-11. CRITICAL ITEMS

a. The Defense Medical Standardization Board (DMSB), Fort Detrick, Maryland, maintains a list of critical items needed for patient care during contingencies. The contents of this list are based on input from the military services and other DoD agencies that manage medical materiel. Periodic analysis of quantities of these critical items held by the military services and other DoD agencies is requested by the Assistant Secretary of Defense for Health Affairs to ensure DoD capabilities will meet contingency requirements.

b. The various Tri-Service Regional materiel standardization committees will review products included on the critical items list to ensure they are considered for standardization at their regional MTFs. The Health Care Activity (HCA) materiel standardization committee works in concert with the RMC to ensure the Tri-Service Region has these items for review and incorporation into the activities' stockage lists.

3-12. JOINT DEPLOYMENT FORMULARY

a. The DMSB, Fort Detrick, Maryland, maintains the Joint Deployment Formulary (JDF). The JDF's purpose is to establish a baseline deployment formulary to treat the most common wounds or diseases that may affect a US Armed Forces member. Inclusion must balance transportation and inventory management capabilities. It is assumed that Service members will deploy with 180 day supply of medications with resupply through Tricare Mail Order Pharmacy (TMOP).

b. The JDF is the pharmaceutical items that have been approved by all four Services for use in a Deployed Theater. The JDF is sourced against the Prime Vendors and the manufacturer's current availability to decrease the number of back orders and rejected requisitions an activity will receive while ordering in a deployed location. The USAMMA uses the JDF when updating and refilling medical assemblages.

c. The JDF is updated quarterly and is available on the DMSB Web site, https://www.dmsb.army.mil .

3-13. STOCKAGE LEVELS

a. Computing reorder points

(1) Compute reorder points with a safety level not exceeding 5 days (15 days for OCONUS) and the actual Order and Shipping Time (OST) for each item. The OTSG is the approval authority for requesting safety level modifications in DMLSS or TAMMIS. The OST for nonstandard items will include the average time used for processing a procurement request.

(2) The preferred method to compute reorder point is the Days Of Supply (DOS) procedures. This is used for distributed/PV/Electronic Catalog (ECAT) items and for all items in a deployed theater.

(3) You may use the Economic Order Quantity (EOQ) procedures to compute the reorder point, see *DA PAM 710-2-2*, Appendix D, for EOQ Reorder Point with appropriate Safety Level.

b. Computing Requisition Objectives (RO)/levels

(1) DOS is the preferred method for PV/ECAT items.

(2) Use *DA PAM 710-2-2* when computing EOQ.

(3) The operating level is a maximum of 15 days CONUS (30 days OCONUS) or as determined by the MACOM/command surgeon when establishing the days-of-supply method. Operating levels for nonstandard items acquired under vendor service are based on quantities needed to sustain operations between resupply cycles.

c. Calculating retention levels. When stock on-hand exceeds the RO/level, medical activities will calculate retention levels using provisions of *AR 710-2* and *DA PAM 710-2-2*. Process stocks exceeding authorized retention levels using the excess materiel guidance in this chapter.

d. Calculating stockage levels for MTOE Medical Supply Operations;

(1) The Command Surgeon determines the peacetime stockage objective for the MTOE medical supply operations. The stockage objective should not exceed 90 days.

(2) The MTOE medical supply operations will use the DOS method or the inventory management module of an approved IS to compute the RO/level. Logistics support plans should establish days of supply needed to support designated unit operations when mobilized.

3-14. REQUISITION PROCEDURES

a. The IMSA/MEDLOG Bn/USAMMCE must provide responsive support to customers for medical items. Ways of providing this support are:

(1) The preferred method is through a commercial contract service, such as the DoD PV/ECAT.

(2) Local stockage of selected items will be used when:

(a) The distance between the IMSA/MEDLOG Bn/USAMMCE and the supporting commercial distributors warrants stocking items to preclude interrupting supply support.

(b) Items are not available through supporting commercial distributors.

(c) When item are ordered in unit of issue and sold by unit of measure.

(3) When the commercial distribution contracts cannot fill routine supply requirements, CONUS IMSAs/MEDLOG Bn will submit requisitions to DSCP using MILSTRIP procedures delineated in *AR 725-50*.

(4) Local purchase procedures (Decentralized Blanket Purchase Agreements (DBPA)/Blanket Purchase Agreement (BPA)/Credit Card) program. Use of DBPA is restricted to the 16th MEDLOG Bn/Korea, and USAMMCE.

b. IMSA/MEDLOG Bn/USAMMCE will enter all purchases and receipts in DMLSS/TAMMIS for retrospective review by the Accountable Officer, to capture demands for standardization, analyze procurement costs, and to ensure items are purchased using the most efficient acquisition methodology.

c. To requisition regulated medical items and/or provisioned medical equipment items, follow procedures in this chapter.

d. Requisition Medical Care Support Equipment (MEDCASE) items by following guidance in *SB 8-75-MEDCASE*, the USAMMA, and local command publications. The supporting property account will forward MEDCASE requisitions directly to the USAMMA. These requisitions will not be processed through the IMSA/USAMMCE. Capital Expense Equipment Program (CEEP) will be direct-fund cited when requisitioned through the medical supply account.

3-15. REQUISITIONING STANDARD AND NONSTANDARD MEDICAL MATERIEL

a. Standard stocked items: The OCONUS IMSA/MEDLOG Bn/USAMMCE may transceive an “A01” (request for standard stocked item), “A0A” for CONUS IMSA/MEDLOG Bn, requisitions through the Defense Automatic Addressing System (DAAS) to the supply source if the requisitions:

(1) Comply with local policies and procedures.

(2) Are in MILSTRIP format (See *AR 725-50*).

(3) Are for medical materiel centrally cataloged by DSCP and listed in one of the following publications:

- AMDF or FEDLOG.
- UDR MEDCAT
- Medical Services Information Logistics Systems (MEDSILS), http://www.usamma.army.mil/apps/qbca_medsils/

b. Nonstandard nonstocked items: The OCONUS IMSA/MEDLOG Bn/USAMMCE may transceive Document Identifier Code (DIC) “A05” (nonstandard nonstocked items) requisitions through DAAS to the supply source if the requisitions:

(1) Comply with local policies and procedures.

(2) Are for medical materiel not listed in either the:

- AMDF, MEDSILS, FEDLOG,
- UDR MEDCAT
- Medical Services Information Logistics Systems (MEDSILS), http://www.usamma.army.mil/apps/qbca_medsils/

(3) Are accompanied by all applicable exception data.

(4) Are prepared per procedures in *AR 725-50*.

c. Nonstandard medical materiel:

(1) The CONUS IMSA/MEDLOG Bns will purchase nonstandard medical materiel locally. However, when the item cannot be locally obtained, requisitions may be submitted to DSCP citing:

- DIC “AOE”.
- Pertinent exception data.
- Advice code “2A”.

(2) The MTOE medical supply operations will submit requisitions to their supporting IMSA/MEDLOG Bn/USAMMCE.

3-16. EMERGENCY REQUISITIONS

a. When emergency or urgent medical materiel requirements exist (to save lives or to prevent suffering or distress), IMSA/MEDLOG Bn/USAMMCE will expeditiously process requisitions from supported HCAs using the issue priority designator “03” (life or death) requisitions. Life or death requisitions will be submitted to DSCP only when the item is not available locally. The quantity ordered should reflect the minimum requirements for the particular emergency. Particular attention should be given to customer’s requests for in-vitro diagnostics and reagents. Because of the type of materiel involved, activities should be certain that a life or death situation is involved before submitting the requisition on that basis. Non-receipt of incremental shipments is not in itself a justification for submitting a life or death requisition. Submit requisitions telephonically to the Emergency Supply Operations Center (ESOC) at DSCP. Normal duty hour numbers are commercial 215 737-2112 or DSN 444-2112. After duty hour numbers are commercial 215 737-2341 or DSN 444-2341.

b. The following information, at a minimum, is required on the requisitions:

- Name of the physician administering to the patient.
- Diagnosis and prognosis of patient(s).
- Preferred mode of shipment.
- Requisitioner’s telephone numbers (on & after duty) and points of contact.

c. The commander or designated representative will personally review and document all requisitions with an urgency of need designator “A” or “B” per the *DA Pam 710-2 series*. The IMSA/MEDLOG Bn/USAMMCE will perpetuate all urgency of need designator “A” requisitions from supported activities.

d. Valid exception data for urgency of need designator “A” and “B” requisitions are requests for shipment using:

(1) The fastest traceable means.

(2) Shipments by specific mode (i.e., commercial air). If commercial air is requested, IMSA/MEDLOG Bn/USAMMCE will provide an appropriate transportation fund citation. Do not delay life or death “03” requisitions to verify or determine the appropriate fund cite.

e. When MTOE medical supply operations submit emergency urgency of need designator “A” and “B” requisitions to their supporting IMSA/MEDLOG Bn/USAMMCE, the unit commander will authenticate the priority assigned to the requisition per the *DA PAM 710-2 series.* The MTOE medical supply operation will process emergency requisitions from supported units. The requisition must be properly authenticated, provided the requisitions cannot be filled from on-hand stocks.

3-17. PRIME VENDOR AND ELECTRONIC CATALOG AS A SOURCE OF SUPPLY

a. The overall goal for materiel acquisition is to migrate to greater use of electronic commerce alternatives and decrease reliance on manual, labor-intensive procurements, such

as credit cards. Two programs that maximize use of e-commerce methodologies and provide greater system-wide economies are the DSCP PV and the ECAT programs.

b. The DSCP pharmaceutical and MEDSURG PV/ECATs are the commercial distributors for items, which include:

- Distribution and Pricing Agreement (DAPA) items;
- Federal Supply Schedule items;
- PV/ECAT non-usage items;
- PV/ECAT committed volume/Regional Incentive Agreements (RIA) items; and
- Other e-tool sources.

This program is mandatory for USAMEDCOM activities for products available under the program and serves as the primary acquisition method for pharmaceuticals and MEDSURG materiel.

c. Actions to be taken by the activity to increase PV utilization:

(1) Communicate weekly with the PV representative.
(2) Ensure all non-usage items are ordered under a specific Routing Identifier Code (RIC).
(3) Request items that can be provided by the PV to be stocked if they are not in the PV distribution center.
(4) Review and adjust usage levels with the PV representative monthly.
(5) Continuously review local purchase and credit card purchases with the PV representative for PV eligible items.
(6) Consider utilizing DOS versus EOQ for inventory management.
(7) Order smaller quantities more frequently.

d. The activity should ensure the PV is accomplishing the following tasks to increase utilization:

(1) Weekly communication with the activity.
(2) Notify the activity when usage items are stocked.
(3) Notify the activity when backordered items are received.
(4) Furnish the activity listings of items stocked by the distribution center.
(5) Minimize temporary out of stock. Address the temporary out of stock items routinely (minimum at the weekly meeting) with the activity.
(6) Capture demands on kills/cancellations.

e. Actions to be taken by the activity to increase PV fill rate of usage items:

(1) Work rejects daily. Some rejects can be caused or affected by the activity:
R1 – Not on Contract
R2 – Invalid Item Identification
R3 – Invalid Unit of Issue
R6 – Not on Customer Usage List
R7- Reorder as Drop Shipment
AR – Quantity Exceeds Allocation
AA – Customer Exceeded Forecasted Demand Quantity
The PV should work the other rejects.

(2) Reconcile usage versus non-usage items on a monthly basis with the PV representative.
(3) Order more frequently for smaller quantities.
(4) Do not permit the logistics IS to automatically reorder temporary out of stock or backordered items on a daily basis, if the item cannot be filled by the PV in a reasonable period of time. Such continuous reordering does nothing to obtain the item and increases the number of unfilled/cancelled requisitions, thereby lowering the fill rate.

f. The activity should ensure that the PV accomplishes the following tasks to increase the fill rate:

(1) Notify activity when usage items are restocked (removed from backorder status).

(2) Notify activity when usage candidate is entered as usage in the PV system.

(3) Work with the activity on a daily basis to address rejects that are not caused by the activity (e.g., temporary out of stock, R4 – Manufacturer/National Backorder).

(4) Notify activity when a non-usage item has enough demands to convert to usage.

g. The DSCP ECAT program continues to expand and is used for laboratory, optical, dental, medical equipment, manufacturer-direct and general MEDSURG items (available under ECAT Joint Venture Program). The program minimizes administrative workload, overhead costs and interest payments by streamlining electronic ordering and financial processes through the Military Standard Billing System (MILSBILLS). This program is mandatory for USAMEDCOM activities for products available under the program. A full description of the functionality and features of the DSCP ECAT system can be found at the ECAT webpage: https://dmmonline.dscp.dla.mil/ECAT_Nonsecure/ecat_home.asp .

3-18. VENDOR INVENTORY SERVICE

a. The IMSA/MEDLOG Bn/USAMMCE will use direct-order and other electronic vendor (INTERNET based) inventory services provided by commercial medical materiel distribution organizations PV. The DSCP Pharmaceutical and MEDSURG PV's provide on-demand shipment of materiel.

b. The IMSA/MEDLOG Bn/USAMMCE will use these services to augment in-house capabilities for standard and nonstandard items and services. This augmentation provides significant benefits for managing short shelf life items.

c. The IMSA/USAMMCE will use PV inventory services as an alternative to stocking and a means to reducing inventory at the installation level.

d. Where appropriate, the IMSA/MEDLOG Bn/USAMMCE may authorize other SSAs and customers to use direct order and other electronic vendor-inventory services to satisfy supply requirements. All authorizations of adding other customers must be coordinated and approved by higher commands and the MEDCOM (MCLO-O). The DSCP PV and ECAT systems are the AMEDD number one means of acquisition. All materiel must be bought through these systems when the products are available. ECAT prices can be higher at times and the activity needs to make a judgment call to acquire it if it makes economic sense. The activity needs to challenge the higher price with the DSCP ECAT Help Desk at 800-290-8201 or dscpecathelp@dla.mil.

3-19. DEPARTMENT OF VETERANS AFFAIRS (DVA) AS A SOURCE OF MEDICAL MATERIEL

The DVA is a source of medical materiel that is authorized for local purchase. The DVA contracts with firms for common use supplies and services, and these contracts are summarized in the *Federal Supply Schedule (*FSS). When making local purchases from the *FSS* source, follow the provisions in the Federal Acquisition Regulation (FAR).

3-20. LOCAL PURCHASE FOR MEDICAL MATERIEL AND SERVICES

The preferred purchasing methodology is the contracted DSCP commercial distributor/ PV/ECAT. When the PV/ECAT is unable to meet the requirement, local purchase may be utilized. The IMSA/MEDLOG Bn/USAMMCE should consider the following when local acquisition of materiel is appropriate.

a. The IMSA/MEDLOG Bn/USAMMCE will use local purchase procedures to satisfy supply requirements of supported customers. Methods of local purchase include:

(1) Direct-order and other electronic (INTERNET based) vendor-inventory services.

(2) Decentralized Blanket Purchase Agreements (DBPAs). Use of DSCP DBPAs is restricted to the 16th MEDLOG Bn/Korea, and USAMMCE.

(3) Supporting contracting office where deemed appropriate by the MSO.

(4) International Merchant Purchase Authorization Card (IMPAC) program/government purchase card/credit card.

b. The MTOE medical supply operations will obtain local purchase support through their supporting IMSA/MEDLOG Bn/USAMMCE. The activities should comply with IMSA/MEDLOG Bn/USAMMCE procedures when submitting Purchase Requests (PRs).

c. The PRs must:

(1) Be made on a competitive basis to the maximum extent possible.

(2) Establish and describe requirements for products and services based on actual needs of the government, not personal preference, and on the minimum essential characteristics required to perform the mission.

d. When government needs are such that only a particular product is acceptable, the customer will attach a justification for other-than-full-and-open competition to the PR. Activities should consider equipment compatibility and other conditions or circumstances that may necessitate sole source procurement. Additional to the factual statement, PRs will include facts concerning test and evaluation of potential products and will identify competitive products to the maximum extent possible. The factual statement should:

(1) Cite the physical, functional, or other characteristics essential to the needs of the government.

(2) Identify the physical and functional characteristics peculiar to the requested product or service.

e. The PRs must include all available information needed to receive the desired materiel. Complete information will prevent unneeded correspondence and will reduce lead-time.

f. USAMEDCOM activities will attach the properly completed Contract Data Distribution Form, USAMEDCOM Form 757-R (MCRM) dated Jun 05 to all purchase requests (DA Form 3953, DD 1348-6 or PR Web), except for acquisition to be paid by credit card. This action will assist DFAS – Vendor Pay in prompt payments of goods and services. The Group Administration Manager or Contracting Officer's Representative (COR) will ensure this data is kept current and accurate at all times by notifying the Wide Area Work Flow (WAWF) POC at the contracting office.

g. Coordination between the customer, supporting medical maintenance activity, and the facility engineer must be accomplished during the planning stage to determine structural and utility requirements for equipment requiring installation.

h. The MSO or designated representative will review all PRs to:

(1) Identify maintenance significant equipment

(2) Determine maintenance requirements

(3) Assist the customer in procurement specifications.

i. The PRs for maintenance significant equipment must include a request for two copies of operator and maintenance manuals. The ordering activity can adjust this figure to meet local requirements. Digital or electronic manuals may be provided instead of hard copy manuals.

(1) Operator manuals should include instructions on the following:

(a) Assembly

(b) Operation

(c) Services

(d) Accessories

(e) Calibration, if applicable

(2) Maintenance manuals should include instructions on the:
(a) Assembly
(b) Installation
(c) Troubleshooting
(d) Calibration requirements
(e) Utility schematics/wiring diagrams
(f) Applicable parts requirements

j. The Principle Assistant Responsible for Contracting (PARC) is the proponent for the IMPAC credit card program. The USAMEDCOM activities will use only IMPAC cards issued by the USAMEDCOM contracting offices. The USAMEDCOM contracting offices will provide the following types of guidance.

(1) Clarification of advise from the Assistant Secretary of the Army for Research, Development, and Acquisition (ASARDA), to include providing interpretations, clarification, and resolution of conflict between implementing activities and ASARDA.

(2) The USAMEDCOM policies and responsibilities regarding the IMPAC program.

(3) Monitoring and reporting USAMEDCOM progress to ASARDA.

k. Logistical responsibilities are identified in PARC memorandums and implementation plan for purchasing of supplies, equipment, and services.

3-21. LOCAL PURCHASE OF SELECTED ITEMS OF MEDICAL MATERIEL

The following medical materiel and equipment can be purchased locally:

a. Items, Including Repair Parts Required Immediately: These items are needed to save lives or prevent suffering and can be purchased by following normal supply and financial procedures. The *DFAS-IN Regulation 37-1* authorizes that these purchases, if necessary, be made in the absence of funds. *AR 40-2* outlines the standards for purchasing drugs and immunizing agents.

b. Occupational Therapy Supplies And Equipment: These items are authorized for use by occupational therapists.

c. Professional Books And Periodicals: These include all library material required by health care personnel involved in direct or indirect patient care.

(1) The OCONUS activities may order medical books and periodicals through DBPAs awarded by DSCP. If the required materiel is not available through DBPAs, send requisition to DSCP at MEDESOC@DLA.Mil. Telephones: Commercial 215-737-2112, Option 1; DSN 444-1212.

(2) Subscriptions for periodicals and journals may exceed one (1) year when it is more cost effective.

(3) To obtain a limited number of books, the FSS for Federal Supply Group 76 may be used.

d. WIGS (Cranial Prostheses): These can be supplied to:
(1) Females with alopecia (hair loss) or
(2) Males with alopecia under the following conditions:
(a) Secondary to specialized medical treatment
(b) Along with disfiguring scars
(c) Resulting in psychiatric disorders, and in the medical authority's opinion, the wig would be beneficial therapy.

e. Post-Mastectomy Prostheses And Brassieres. The HCA commander must authorize the post-mastectomy prostheses, brassieres, and wigs as part of the overall course of treatment.

f. Medicinal Gases: These can be purchased only when available in satisfactory quality and volume per U.S. Pharmacopoeia standards. Available from:

U.S. Pharmacopoeia
12601 Twinbrook Parkway
Rockville MD 20852
Telephone 800-822-8772

g. Furniture and furnishings for clinical, waiting, and lounge areas.

h. Contact Lenses when authorized by *AR 40-63*/*Navy Medical Command Instruction (NAVMEDCOMINST) 6810.1*/ Air Force Regulation (*AFR) 167-3*.

i. Prosthetic Devices, Implants, Appliances, And Accessories (*see AR 40-3*).

j. The MEDCASE Requirements: See *SB 8-75-MEDCASE*.

k. Prescription Safety Glasses: Prescription safety glasses are authorized solely for a specific job assignment per *AR 40-63*, *Technical Bulletin Medical 506 (TB MED 506*) and *Common Table of Allowances (CTA) 50-900*. Prescription safety glasses are authorized to members of the uniformed services only on a non-reimbursable basis. Procedures to obtain safety glasses for Federal civilian employees are contained in *TB MED 506*.

l. Medical Research Mission Or Environmental Laboratory Materiel: The laboratory commander must authorize this materiel.

3-22. LOCAL PURCHASE RESTRICTIONS

a. Purchase only Food and Drug Administration (FDA)-approved drugs; exceptions are listed *in AR 40-2* and *AR 40-7.*

b. Do not purchase vaccines and immunizing agents locally unless one or more of the following conditions have been met:

(1) The item is listed in the AMDF, FEDLOG UDR MEDCAT or MEDSILS
(2) The Army has approved or recommended the item for use
(3) The Surgeon General has specifically approved the item

c. Do not purchase nonstandard equipment, for which a standard comparable item is available, unless it provides features that are clearly needed in the health care service.

d. Do not purchase standard or nonstandard items needed for facility alterations, additions, expansions, or minor new construction before approval and funding of the construction project.

e. Follow the restrictions contained in the FAR and any supplements to purchase items of foreign origin.

f. Purchase infant transport under these conditions:

(1) When transport incubators or bassinets are used solely for ground transport. These items must be FDA approved.

(2) When infant incubators are used for air transport, the items must have been previously approved by the

U.S. Air Force Aeromedical Testing Branch
311 Human Systems Wing/YAML
Bldg. 160, Room 134
2485 Gillingham Drive
Brooks Air Force Base
San Antonio TX 78235-5105

g. Do not purchase or use investigational drugs without the prior written approval from TSG. Submit requests for approval to the U.S. Army Medical Materiel Development Activity (USAMMDA):

Commander, USAMMDA
ATTN: MCMR-UMZ
622 Neiman Street
Fort Detrick MD 21702-5009

AR 40-7 contains additional guidance on investigational drugs.

h. Do not purchase or issue drugs classified “ineffective 1A” by the FDA.

i. Do not purchase regulated medical items (see Glossary) and those authorized in major medical assemblages (*SB 8-75 Series*) without approval of TSG.

j. Purchase orthopedic footwear for authorized individuals using guidance in:
- *AR 32-4* - *DLAR 4235.18* - *AFR 67-125/*
- *Navy Supply Instruction (NAVSUPINST) 4400.70C*
- *Marine Corps Order (MCO) 4400.137A*
- *AR 700-84* and *AR 40-3.*

k. Purchase hearing aids, batteries, and replacement ear molds through the medical supply channels from the DVA acquisition sources.

l. Do not purchase diagnostic imaging systems unless authorized by the USAMMA.

m. Purchase infant feeding formula using purchase orders, PRs, or BPAs. The IMSA/MEDLOG Bns/USAMMCE may receive formula at no cost as long as the authorized purchase order, PRs, or BPAs call numbers have been processed using prescribed procurement procedures established by the supporting contracting office.

n. Do not purchase investigational equipment not yet certified by the FDA without TSG approval. Submit requests for approval through command channels to

Commander, USAMEDCOM
ATTN: MCLO-O
2050 Worth Road, Suite 8
Fort Sam Houston TX 78234-6100

o. The installation’s preventive medicine service, in coordination with the safety committee, will define, develop, and/or review approval procedures for purchasing medical materiel locally. These procedures must mitigate potential harmful health and environmental effects. The MSO will request the Materiel Safety data Sheet(s) (MSDS) from the manufacturer.

p. Any equipment, supplies, or services offered to the U.S. Government by a contractor on a “no cost” basis will follow the procedures and regulations that are in:

(1) *AR 1-100* and *AR 1-101.*

(2) *FAR* and *DoD Federal Acquisition Regulation* (DFAR) Supplement (contract or purchase order).

q. The term “no cost” includes:

(1) Equipment, supplies, or services provided as a gift or donation to the government.

(2) Equipment or supplies provided to the U.S. Government for determining suitability for future purchases by the government, whether or not the items are consumed through use.

(3) Equipment temporarily loaned to the government.

(4) Equipment or supplies provided to the government either on a temporary or permanent basis, but conditioned upon purchase.

r. An evaluation must be made to determine total cost to the government under any of the methods described above. The evaluation should include all applicable costs (i.e., consumable supplies, transportation, maintenance, training, site preparation, installation, and associated equipment).

s. If the contracting method is chosen as the most appropriate means of acquiring materiel or services, the following applies:

(1) A valid requirement must exist for the materiel or service.

(2) A provision will be included in the contract concerning the ownership and disposition of the "no cost" equipment and/or supplies in the event the contract is terminated or not renewed.

(3) Administrative or regulatory approvals required for automatic data processing, word processing, office automation system equipment, or MEDCASE will be obtained prior to submission of PRs to the contracting office, whether or not these items are offered at "no cost" to the government.

(4) A PR will be submitted per local procedures to the supporting contracting office. The PR will detail all known costs determined by the evaluation.

t. Property accountability will be established upon receipt of the property for all equipment items either as government owned or other-than-government owned, depending on the status of the equipment.

3-23. REQUISITIONING ITEMS IN SUPPORT OF MEDICAL EVACUATION

a. Annually the USAMMA will publish a list of items required in the medical evacuation system in the *SB 8-75 series*. This list includes a project code to be used when requisitioning these items for use in medical evacuation. During wartime, the USAMMA may announce additional items through messages as well as subsequent publications of the *SB 8-75 series*.

b. Submit requisitions citing the appropriate project code to DSCP. Only requisitions for medical evacuation purposes may cite this project code. The DSCP will fill the requisition from a special pool of assets, when available. The DSCP will also provide the appropriate MILSTRIP supply status. Materiel issued from this pool will consist of used, serviceable stocks rather than new, unused stocks. The DSCP will bill at:

(1) Ten percent (10%) of the standard unit price for those requisitions filled from the special asset pool and for issues of used, serviceable items made to support activities by IMSA/MEDLOG Bns/USAMMCE.

(2) Only ten percent (10%) of the standard unit price for issues of used, serviceable items made to support activities by IMSA/MEDLOG Bns/USAMMCE.

(3) The standard unit price for those requisitions not filled from the special asset pool.

3-24. PURCHASING SERVICES AND RENTALS

a. The *FAR*, as supplemented, provides guidance concerning contracting for personal and non-personal services. Non-personal services may be locally purchased. Examples of non-personal services are as follows:

(1) Repairs to medical equipment when in-house maintenance capability is inadequate

(2) Installation of equipment when not included with the original contract

(3) Consultation services.

b. Rent or lease equipment when:

(1) Needed to satisfy an emergency medical requirement

(2) Available only through lease

(3) The lease is more cost effective than purchasing

c. Follow property accountability guidelines for all rented or leased equipment.

3-25. PURCHASING SPECIAL DENTAL MATERIEL

a. The DSCP has established indefinite requirements contracts and DBPAs with various companies to purchase prosthodontic supplies, to include:

(1) Artificial teeth
(2) Facings
(3) Backings
(4) Mold guides
(5) Orthodontic supplies
(6) Partial denture casting alloys and accessories
(7) Other dental accessories and materiel

b. Purchase procedures for dental materiel are as follows:

(1) Use of the commercial distribution contracts or DSCP's ECAT program.
(2) Use of DBPAs by activities that provide orthodontic care.

3-26. MEDICAL EQUIPMENT AND PROVISIONED ITEMS

a. Medical equipment end items purchased for field use and requiring unique support and maintenance will be procured with the following provisioned items:

(1) Transportation/carrying case0
(2) Accessories and consumables required for item to be functional when received (3-day start-up kit)
(3) Operator and maintenance manuals (1 hard copy, 1 electronic copy)
(4) Training material, to include Operator & Maintenance materials
(5) Consumables and accessories item list

b. Medical equipment and provisioned items will be assigned a model-specific Acquisition Advice Code (AAC) "J" National Stock Number (NSN). The AAC "J" NSN will be used for procurement of the equipment items. The items to support and maintain the make/model specific medical equipment and provisioned items will be requisitioned using an AAC of "L."

c. Medical equipment and provisioned items can be Other Procurement, Army (OPA) or OMA funded as determined by the appropriation and budget activity account code of the Materiel Category Structure Code (MCSC) in the AMDF or FEDLOG.

d. The USAMMA will centrally fund all new components, both OPA and OMA, identified to a Unit Assemblage (UA) for Units being sustained. All other units are to keep their sets maintained to the as fielded UA listing. If a Unit Commander determines they are procuring the updates, notification to the USAMMA is requested.

e. The USAMMA messages will announce provisioned medical items, which are available on the USAMMA website (http://www.usamma.army.mil).

f. Basic requisitioning procedures for all procurement appropriation provisioned medical equipment items are as follows:

(1) Prepare standard MILSTRIP requisitions per *AR 725-50*.
(2) Forward requisitions through appropriate Class VIII supply channels to the USAMMA for funding and requirement validation review.
(3) Use "AOE" or "AO5" as the DIC for all requisitions.
(4) Use "B69" as the RIC for all requisitions for AAC "J" end items to the USAMMA.
(5) Include a valid sole source justification with requisitions for AAC "J" NSNs. If not included, the requisition will be canceled and returned to the requesting unit.

(6) Use the requesting Unit's Department of Defense Activity Address Code (DODAAC) in the requisition's document number. If the supporting automated system requires the DODACC SSA in the document number, then identify the requesting unit in the supplementary address field. All requisitions will contain the original requester's complete document number and the in-the-clear name of the unit, i.e., 228th Combat Support Hospital (CSH), in the EXCEPTION DATA accompanying the requisition.

(7) Submit the requisition to the USAMMA by message with an information copy to the appropriate MACOM. Mail may be used as an alternative submission method. Do not submit requests for Procurement Appropriations provisioned medical equipment items through the DAAS.

(8) Include the following information in the exception data for each requisition (the requesting unit must furnish this information).

(a) Current authorization (MTOE and effective date).

(b) Unit Identity Code (UIC).

(c) Reason for shortage (that is, initial issue or replacement).

g. The USAMMA will forward all validated and funded requisitions to the appropriate contract vehicle for procurement.

3-27. PURCHASING REFERENCE BOOK SETS FOR MEDICAL MTOE UNITS

a. The MTOE and other Army authorization documents authorize the book sets for MTOE units. The Army Medical Department Center & School (AMEDDC&S) will:

(1) Determine the components of book sets.

(2) Review book sets annually.

(3) Publish through the USAMMA and USAPD, the revised component listings in the *SB 8-75-S9* (20 September).

b. To obtain individual books for book sets:

(1) Use local purchase procedures (see instructions in *SB 8-75-S9* dated 20 September).

(2) Use current general services, administration FSS, and FSG 76.

3-28. INVENTORY ACCOUNTING

Use the following accounting methods for stocks. These procedures apply to manual systems and logistics ISs.

a. The IMSA/USAMMCE/MEDLOG Bn maintains accountable records using guidance in *AR 710-2*, *DA PAM 710-2-2*, and this *SB*.

b. Other MTOE medical supply operations will maintain informal inventory accounting records. These records should be maintained per *AR 710-2* and *DA PAM 710-2-2*. Accurate maintenance of these records will maximize efficiency and accuracy of records and effectiveness of training.

c. Medical MTOE units will account for items stocked and for components of medical assemblages.

3-29. INVENTORY AND ADJUSTMENT

a. The IMSAs, MEDLOG Bn, USAMMCE, and other medical supply operations must follow procedures in *AR 710-2* and *AR 735-5*, *DA PAM 710-2-2* and *DFAS-IN Reg. 37-1*, when inventorying and adjusting medical stocks.

b. The HCA commanders (Lieutenant Colonel or above) will approve inventory adjustments for IMSAs. Delegation of this authority must follow the guidance set forth in *AR 735-5*. This authority cannot be delegated to the Chief of Logistics at a medical activity.

c. The goal for inventory adjustment (gains and losses) is to keep the adjustment below five percent of the RO/level dollar value per fiscal year (*AR 735-5*).

d. A disinterested officer appointed on orders will inventory controlled medical items monthly, to account for the items.

e. The MSO must conduct causative research on all lines having a dollar value adjustment of $1,000, and on all controlled item discrepancies regardless of value.

3-30. REQUISITION SUPPORT PROCEDURES FOR MEDICAL ACTIVITIES ORDERING EXPENDABLE, DURABLE AND NON-EXPENDABLE MATERIEL

a. Organizational elements of TDA HCAs will submit requests for;

(1) **Non-Medical Durable and all Non-Expendable** materiel to the supporting Property Management division/branch.

(2) **Medical Durable and all Expendable** materiel to the supporting Materiel division/branch.

(3) **Self Service Supplies** available through E-Mall will be ordered through established channels.

(4) **Mandatory Blanket Purchase Agreements (BPAs) for Office Supplies**.

(a) 21 September 2004, mandatory Army BPAs became effective for Army-wide purchase of office supplies using the IMPAC purchase card. They are located on the Department of Defense (DoD) Electronic-MALL website: https://emall6.prod.dodonline.net/common/resources/Shop.jsp . Cardholders are no longer authorized to place office supply orders directly through vendors, General Services Administration (GSA) Advantage, or locally established BPAs and contracts.

(b) BPAs are established to standardize the ordering process and provide cost-effective, customer-focused delivery of office products while complying with statutory requirements to purchase comparable products available from the blind and severely disabled vendors under the JWOD Program.

(c) Users must LOGON to the EMALL and establish an account using DODAAC beginning with a "W". If unable to access the EMALL,

- Contact the help desk at 1-877-352-2255 or DSN 661-7766.
- Customers outside of the U S (OCONUS) should call 1-269-961-7766 or DSN 661-7766 and select EMALL from the menu or email https://emall6.prod.dodonline.net/general_information/Help.jsp . (Use of the DoD EMALL requires Netscape Navigator 4.04+ or later or Internet Explorer 4.0+ or later with both cookies and Java Script enabled).

(d) Exceptions to the mandatory use of the BPAs and DoD EMALL are as follows:

- If the DoD EMALL is unavailable for more than 24 hours, cardholders may place an order with a BPA vendor through another form of communication.

- If an installation agreement exists, cardholders will purchase office products from local alternative self service supply stores known as base support.

- If the lowest price for a mandatory JWOD product among the three potential sources (BPA vendor, Non-BPA vendor, and the base support store) is above fair market value, the product may be purchased at the most economical price by any means. In such a case, document the prices and notify the Army JWOD point of contact (POC) by calling 703-696-5069.
- If an urgent office product requirement exists, cardholders may purchase the urgent required products through non-BPA sources. The cardholder's file must appropriately document the reason for not using the BPAs.

b. Units and activities having an assigned DODAAC will submit requests for expendable, durable, and non-expendable medical items to the IMSA/MEDLOG Bn/USAMMCE per *AR 710-2*, *DA PAMs 710-2-1* and *710-2-2*, and MACOM/Command Surgeon guidance. The IMSA/MEDLOG Bn/USAMMCE will arrange for the technical acceptance inspection of maintenance significant equipment before issuing to the requesting activity.

c. Requesting activities will designate personnel authorized to request and receive medical supplies and equipment. A DA Form 1687 (Notice of Delegation of Authority - Receipt for Supplies) will be used for this purpose. Distinction will be made between those authorized to order and receive controlled and sensitive items and other medical materiel. The IMSA/ MEDLOG Bn/USAMMCE and other medical supply operations will maintain a current file of completed DA Form 1687s on customers. These procedures are outlined in *DA PAM 710-2-1*.

3-31. MATERIEL OBLIGATION VALIDATION

a. The IMSA/MEDLOG Bn/USAMMCE will:

(1) Conduct monthly customer due-out reconciliation [Materiel Obligation Validation (MOV)] with supported customers. The customers must complete a local reconciliation before the quarterly NICP MOV process begins (see *AR 725-50*).

(2) Review MOV requests with the customers to ensure proper use of funds and the need for continued supply action. Timely response in validating requests from supply sources is essential to ensure ongoing supply action and to prevent cancellation of the request.

b. The MTOE medical supply operations will validate requisitions per local IMSA/MEDLOG Bn/USAMMCE procedures for reconciliation. These MTOE medical supply operations will respond to IMSA/MEDLOG Bn/USAMMCE requests for MOV.

3-32. CONTROLLED MEDICAL ITEMS

a. Identification: The Drug Enforcement Administration (DEA) identifies drugs as controlled substances. The Federal Register and the *SB 8-75 series* contain a list of these drugs and changes that are published annually. The Federal Supply Catalog (FSC) identifies standard controlled substances as Notes “R” and “Q” in the notes column. The AMDF or FEDLOG identify these substances as Controlled Inventory Item Codes (CIICs) “R” and “Q.”

b. Schedule designations. The DEA assigns controlled substances to one of five schedules depending on the degree of control required.

(1) Schedule I - Substances/drugs having no accepted medical use in the U.S.

(2) Schedule II - Substances/drugs having a high abuse potential with severe psychic or physical dependence liability, identified as:

(a) Note “R” in the FSC.

(b) Controlled inventory item code “R” in the AMDF or FEDLOG.

(3) Schedule III - Substances/drugs having an abuse potential less than Schedules I and II substances, identified as:

(a) Note “Q” in the FSC.

(b) Controlled inventory item code “Q” in the AMDF or FEDLOG.

(4) Schedule IV - Substances/drugs having an abuse potential less than Schedule III substance, identified as:

(a) Note “Q” in the FSC.

(b) Controlled inventory item code “Q” in the AMDF or FEDLOG.

(5) Schedule V - Substances/drugs having an abuse potential less than Schedule IV substances, identified as:

(a) Note “Q” in the FSC.

(b) Controlled inventory item code “Q” in the AMDF or FEDLOG.

3-33. SECURITY PRECAUTIONS FOR CONTROLLED MEDICAL ITEMS

a. Controlled medical items such as controlled substances, tax-free alcohol, precious metals, and other items designated by the HCA commander, require security precautions and must follow the guidelines in *AR 190-51* “Security of Unclassified Army Property”. Research, development, test, and evaluation facilities will follow the policies and procedures in *AR 70-65* when managing controlled substances, ethyl alcohol, and hazardous biological substances.

b. Only those Army Activities identified in the *SB 8-75 Series* can requisition controlled substances from DSCP. The DLA system will ship only to those DODAACs cited.

3-34. REQUISITIONING CONTROLLED MEDICAL ITEMS

a. The MACOMs should submit requests for additions and deletions to the list of authorized requisitioners, with justification, through command channels to

Commander, USAMEDCOM
ATTN: MCLO-O
2050 Worth Road, Suite 8
FT Sam Houston TX 78234-6100

b. The USAMEDCOM Commander will:

(1) Advise the submitting command of approved and disapproved requests.

(2) Notify the USAMMA (MCMR-MMB-R) of all approved changes, who in turn, will coordinate with the DSCP. The USAMMA is the originator of the data and is the Service Item Control Center.

(3) Authorized requisitioners will:

(a) Establish procedures that ensure adequate supply support of controlled substances for satellite medical activities.

(b) Ensure that supported activities demonstrate a valid need for controlled substances before issuing.

(4) Unauthorized units should, if controlled substances are needed, contact the nearest authorized requisitioner for supply support.

(5) The DSCP will reject requisitions from unauthorized activities.

(6) Each month, the DSCP will provide MACOMs with a list of controlled substances issued to their subordinate units. The MACOMs will establish procedures with subordinate activities to reconcile the lists with local supply account records on a timely basis. Subordinate activities must report any discrepancies to MACOMs and the DSCP. In addition, the IMSA/MEDLOG Bn/USAMMCE will establish local procedures to reconcile orders from commercial distributors with actual quantities received.

3-35. LOCAL PURCHASE OF CONTROLLED MEDICAL ITEMS

a. All local purchases of controlled medical items must comply with DEA instructions.

b. The HCA commanders may designate a minimum number of essential personnel within the IMSA/MEDLOG Bn/USAMMCE or pharmacy, as authorized to sign exempt certificates for the purchase of controlled substances for official use. TDA activities utilizing DMLSS will enter schedules I and II in DMLSS as Off-Line Non Submit and utilize PO call number generated by DMLSS on DEA Form 225

(1) These designated individuals must be registered with the nearest DEA regional office by completing DEA Form 225 DEA Application Form. After registration, the DEA will

furnish exempt officials the needed order forms (DEA Form 222, U.S. Official Order Form Schedules I and II) and instructions. Store order forms in a locked container. Each certificate must be renewed every 3 years.

(2) When a registered individual is replaced, the HCA will forward the registration and any unused order blanks to

DEA
ATTN: Registration
600 Army Navy Dr., 6th Floor-ODOC
Arlington VA 22202

(3) The OCONUS activities may submit requests to DSCP for their assistance in procuring controlled items.

3-36. STORAGE AND ISSUE OF INSTALLATION STOCKS OF CONTROLLED MEDICAL ITEMS

a. Physical security: Storage facilities will follow the physical security standards in *AR 190-51* for controlled medical items, other medically sensitive items, and all other items.

(1) Store stocks of controlled medical items in a security storage device commensurate with the type and quantity of materiel. The IMSA/MEDLOG Bns/USAMMCE's Accountable Officer will request the local Provost Marshal to survey and document the adequacy of the security per *AR 190-51*.

(2) Safeguard note "R" controlled medical items at each storage location. As a minimum, the security storage device should be a vault of substantial construction with a steel door and combination or key lock. Where small quantities permit, use a safe or steel cabinet (General Services Administration (GSA) Class 5 or equivalent). If the safe or cabinet weighs less than 750 pounds, attach it to a permanent structure to prevent easy removal. New vault construction will meet the DEA's minimum-security standards of non-practitioner handling of Schedule I and II controlled medical items. Existing storage vaults should also include the following:

(a) An electronic alarm system, which, upon unauthorized entry, transmits a signal directly to the appropriate military or civilian law enforcement agency.

(b) A self-closing and self-locking device to be used during normal hours when the vault door is open (frequently called a "day gate").

(3) Store note "Q" controlled medical items in safes or vaults. Where space limitations preclude, store items in a locked cage or secure room that has limited access. New construction of cage storage areas will meet the DEA's security standards. Existing cage storage areas should also include the additional features listed above.

(4) Ethyl alcohol is classified as a Code "R" item. **The guidelines established in this SB for bulk storage of ethyl alcohol take precedence over *AR 190-51 and AR 40-3* until either is superseded**. Store ethyl alcohol in a flameproof container/cabinet or storage area that meets National Fire Protection Association (NFPA) and Occupational Safety and Health Administration (OSHA) standards for storage of a flammable product. To the maximum extent practical, meet the standards in *AR 190-51* for the storage of Code "R" items. However, NFPA and OSHA fire protection standards will take precedence over security requirements. As a minimum, keep the container/cabinet locked or in a secure storage area that has a limited access.

b. Managing controlled medical items.

(1) The HCA Commanders or Command Surgeons will appoint the MSO and at least one alternate to serve as the custodian of the activities' stocks of controlled medical items. The custodians/alternates will:

(a) Post all gain and loss transactions on a DA Form 1296 (Stock Accounting Record) for both stocked and nonstocked items.

(b) Maintain current security container designations and records, to include Standard Form (SF) 700 (Security Container Information), SF 702 (Security Container Check sheet), and reversible "OPEN-CLOSED" signs per *AR 380-5*.

(c) Maintain a record of receipts, issues, and stock balances on DA Form 1296 at the storage site. These records are in addition to the IS accountable stock records that are maintained by the appropriate materiel manager.

(d) Sign for registered mail, parcels, and expressed packages addressed to the IMSA/MEDLOG Bn/USAMMCE.

(e) Issue controlled medical items directly to an authorized recipient, preferably at the security storage site. The custodian must obtain a full signature of the recipient.

(f) Complete the stock record accounting at the storage site immediately after a transaction.

(g) Retain accountable records and supporting documents for three years after the date of the last transaction.

(h) Authorize all issues by editing the requisitions before issue.

(i) Analyze the transactions once each month.

(j) Investigate shortages and unusual requisitions or expenditures immediately; consult with supported activities when necessary; and take corrective action if needed.

(2) The MSO will restrict the issue of all controlled medical items by:

(a) Issuing DEA-designated controlled medical items to the HCA pharmacies for dispersal to patients, wards, clinics, and other areas of the hospital. Hospitals must maintain records of these items per *AR 40-2*.

(b) Issuing DEA-designed controlled medical items to other activities only when authorized by the HCA commander or Command Surgeon.

(c) Issuing tax-free alcohol to hospital pharmacy and laboratory activities and other activities authorized by the commander.

(d) Issuing precious metal, Precious Metal Bearing Scrap (PMBS), and chrome-based metals for dental use to the precious metals coordinators of supported Dental Activities. The coordinator is the only one who can turn in precious metals, PMBS, and chrome-based metals.

(e) Issuing instructions containing precious metals to supported activities authorized such items.

(f) Issuing controlled medical items to authorized Active and Reserve Component MTOE units with written approval from the unit commander.

(3) The local Provost Marshal will complete a local files check on vault custodians/alternates, warehouse personnel, and other personnel having access to controlled medical items or medically sensitive items per *AR 190-51*.

3-37. PERIODIC INVENTORIES OF CONTROLLED MEDICAL ITEMS

a. The HCA Commander or Command Surgeon will:

(1) Change disinterested inventory officer assignments each month.

(2) Provide written inventory procedures based on current Army regulations.

b. The aviation life-support equipment technician will inventory controlled medical items in aviation survival kits when the periodic inspection of the complete kit is completed.

c. The Dental Command and all activities will conduct an inventory of precious metals annually to coincide with the annual quality assurance statement.

d. The inventories and corrective action consist of the following:

(1) Agreement between all stock balances on accountable records at storage locations and the quantities on-hand and the accountable stock record. If these do not agree, they must be reconciled.

(2) Authentication of the balance on stock accounting records at storage locations for each line item inventoried. The inventory officer will:
(a) Make a separate line entry on DA Form 1296 to include the date, abbreviation "INV", quantity on hand, and legible payroll signature.
(b) Submit a report of the inventory to the HCA Commander or Command Surgeon and provide a copy to the IMSA/MEDLOG Bn/USAMMCE.

(3) Corrective actions to clear all discrepancies before the next inventory. The HCA Commander or Command Surgeon will report all irreconcilable shortages immediately to the local Provost Marshal for investigation to establish a basis for subsequent action.

3-38. SHIPMENT OF CONTROLLED MEDICAL ITEMS

a. The custodian of controlled medical items will select and prepare the controlled items for shipment. Items will be held in secure facilities until transferred to a carrier.

b. Separate shipping documents and packing lists will cover the shipments. Both should clearly indicate quantities shipped. For individual controlled substances, the shipping documents and packing lists should indicate "medical supplies." Obliterate all markings from external containers and remark with the term "medical supplies."

c. Ship the controlled medical items by registered parcel post (request return receipt) when securely packed for safe transit. All shipments must comply with weight and size limitations of the U.S. Postal Service.

d. A customs declaration tag is not required for shipments that have been addressed to a military organization by title (for example, Commander or Supply Officer) at U.S. military Post Offices OCONUS.

e. If controlled medical items cannot be shipped by parcel post because of weight or size restrictions, refer to

- AR 55-355 *- NAVSUPINST 4600.70*
- AFR 75-2 *-MCO P4600.14B/DLAR 4500.3*.

f. Shipping documents for controlled medical items sent to or from any OCONUS destination will be marked as indicated in the following statement:

"SPECIAL CARGO - PLACE IN CUSTODY OF CARGO SECURITY OFFICER."

3-39. CONTROLLING NEEDLES AND SYRINGES

The HCA activities will maintain adequate control of needles to prevent misuse or access by unauthorized persons. The storage and security of needles are outlined in *AR 190-51*. Disposable syringes that do not have needles are exempt from this requirement.

3-40. OTHER ITEMS REQUIRING CONTROL

a. The MSO will keep a record of controlled medical items on a DA Form 3862 (Controlled Substances Stock Record). Units with a resupply mission will use DA Form 1296. A disinterested officer, appointed by the commander, will inventory and inspect the items monthly.

b. Where unit storage security is inadequate and operational and readiness is not unduly compromised, store controlled medical item components at the lowest supply level having adequate storage facilities. The supporting IMSA/MEDLOG Bn/USAMMCE may also store these items; however, using unit personnel will inventory the stocks monthly.

(1) When stored at an IMSA/MEDLOG Bn/USAMMCE, commingled with IMSA/MEDLOG Bn/USAMMCE stocks, controlled medical item components are:

(a) Considered contingency stocks.

(b) Assigned a unique project code, if applicable to automated systems.

(c) Inventoried by the IMSA/MEDLOG Bn/USAMMCE.

(2) When stored at an IMSA/MEDLOG Bn/USAMMCE in a container secured by the owning unit, the owning unit will inventory and survey the items.

(3) A Memorandum of Agreement (MOA) between the MTOE medical unit and the IMSA/MEDLOG Bn/USAMMCE will be established to ensure issue procedures of stored controlled medical item components are available when required for mission accomplishment.

3-41. REGULATED MEDICAL ITEMS

a. Medical materiel is a regulated medical item when one or more of the following conditions apply:

(1) The item affects the readiness of MTOE units.

(2) A centrally DA-managed funding program funds the item.

(3) Distribution and redistribution is controlled due to:

(a) Critical supply availability

(b) Unique physical properties of the item and/or its specialized use

b. For management and requisition processing purposes, identify regulated medical items as one of the following types:

(1) Procurement appropriation-funded medical equipment for MTOE units

(2) Medical Assemblages (see *SB 8-75 Series*)

(3) Other specialized medical items whose distribution is centrally managed and controlled.

c. The AMDF or FEDLOG identifies regulated medical items as AAC “A”.

d. Certain medical items may receive a temporary regulated medical item designation due to special distribution requirements. The USAMMA messages will announce the temporary regulated medical item status. These messages are available on the USAMMA website at: **www.usamma.army.mil**

e. Basic requisitioning procedures for all regulated medical items are as follows:

(1) Prepare requisitions per *AR 725-50*.

(2) Use “AOE” or “A05” as the DIC for all requisitions.

(3) Use “B69” as the routing identifier code for all requisitions to the USAMMA.

(4) Use the requesting unit’s DODAAC in the requisition document number. If the supporting automated system requires the DODAAC be used in the document number, then identify the requesting unit in the supplementary address field.

(5) Place the original requester’s complete document number and the in-the-clear name of the unit in the exception data accompanying the requisition.

(6) Transmit the requisition to the USAMMA by message with an information copy to the appropriate MACOM. Mail may be used as an alternative submission method. Do not submit requests for regulated medical items through the DAAS.

(7) Exception data is required for any requisitions for the following MCDM items:

- Doxycycline BT of 30s;
- Ciprofloxacin BT. of 30; and
- Pyridostigmine Bromide Tablets (PBT)

The required exception data is:

(a) Unit Identification Code (UIC); and

(b) Reason for the order, i.e., Individual Service Member initial issue requirement for deployment, component of MES - need Line Item Number s (LIN) of the set and quantity on-hand, other missions). Please refer to *SB 8-75-S7*, dated 2006.

(c) Submit to MCMR-MMO-PM, fax COMM 301-619-4404 or DSN 343-4404.

f. Special requisition procedures are as follows:

(1) Submit requisitions for OPA funded MTOE equipment as follows:

(a) Enter code “GA” as the fund code.

(b) Enter a type requirement code (see *AR 725-50*).

(c) Identify the MES that the regulated medical item is a component of or related to in the exception data accompanying the requisition (for example, MES that comprises a unit’s primary equipment authorization).

(d) Format and transmit ARNG requisitions per the *SB 8-75 series*

(2) Submit requisitions for MESs as follows:

(a) If funded by the requester, the requester will commit the appropriate OMA funds with stock fund code obligation from the requisitioner (for example, SSA).

(b) Enter a type requirement code (see *AR 725-50*).

(c) Include the following statement as exception data to USAR and ARNG requisitions: “Unit is authorized MESs by MTOE (provide MTOE number) and has capability to store and maintain the MESs.”

(d) Include the current authorization, UIC, and reason for shortage, initial issue, or replacement as exception data with each requisition.

(3) Requisition other regulated medical items as follows:

(a) The requester will fund the items if a USAMMA message identifies the item for a special or centrally funded program.

(b) The USAMMA will identify special exception data in a message series.

g. Requisitions for MCDM require exception data as listed in e. above and in *SB 8-75-S7,* To route requisitions for regulated medical items (AAC “A”), follow these procedures:

(1) For CONUS and OCONUS active duty units:

(a) The requester submits requisitions to the supporting IMSA/MEDLOG Bn/USAMMCE.

(b) The IMSA/MEDLOG Bn/USAMMCE sends the requisition to the USAMMA with an information copy to the requester’s MACOM.

(c) The USAMMA validates the requirement with the appropriate MACOM as required.

(2) For USAR units:

(a) The requester submits a requisition through normal channels, in accordance with supporting command’s procedures.

(b) The Major Subordinate Command (MSC) validates the requirement and assigns funds for OMA Reserve-funded items.

(c) The MSC forwards the requisitions to the supporting IMSA/MEDLOG Bn/USAMMCE.

(d) The IMSA/MEDLOG Bn/USAMMCE sends the requisition to the USAMMA for validation.

(3) For ARNG units:

(a) The requester submits a requisition to the USPFO.

(b) The USPFO assigns funds for operations and maintenance, NG-funded items and forwards the requisition with a transmittal letter through:

Chief, National Guard Bureau ATTN: NGB-ARS 111 South George Mason Drive Arlington VA 22204-1382	To	Commander, USAMMA ATTN: MCMR-MMO-PM Fort Detrick MD 21702-5001

h. The USAMMA procures and issues all regulated medical items.

i. The supplier will provide the shipping status to the USAMMA and requesting unit *per AR 725-50*. Requesting units should submit follow-ups to the USAMMA.

3-42. PRECIOUS METALS RECOVERY PROGRAM

a. The Precious Metals Recovery Program (PMRP) provides DoD activities with guidance and the requirements for the identification, accumulation, recovery, and refinement of precious metals from excess and surplus end item, scrap, hypo-solution, and other PMBS. The program's purpose is three-fold:

(1) To promote the economic recovery of precious metals.

(2) To use recovered precious metals for internal DoD purposes or as Government Furnished Materiel.

(3) To protect the environment from excess discharges of silver concentrations in waste effluent.

b. The PMRP recovers gold, silver, and platinum family metals from excess and surplus property. The platinum family includes platinum, palladium, iridium, rhodium, osmium, and ruthenium.

c. The DLA is responsible for administering and monitoring the PMRP. DoD activities are responsible for program participation, to include the identification and the transfer of PMBS to the local Defense Reutilization and Marketing Office (DRMO). The DRMO accumulates and ships PMBS to a recovery contractor for refining. The recovery contractor deposits the refined precious metal to the Defense Industrial Supply Center (DISC) account. The DISC issues the precious metal as government furnished material to government contractors at a minimal charge in return for an equal reduction in cost for manufacture of government products that use these metals.

d. The U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) will insure that MTFs have procedures in place to properly characterize wastes from photo processing (x-ray).

e. The RMC and Command Surgeons will:

(1) Develop a program for the recovery of precious metals by following the guidance in *DoD 4160.21-M*.

(2) Establish program procedures either as a supplement to *SB 8-75-11* or as a separate command regulation for:

(a) Recovering PMBS
(b) Safeguarding recovery equipment and reclaimed scrap
(c) Training using activity personnel
(d) Turn-in of scrap to collection points
(e) Control of the program
(f) Testing of equipment for effectiveness and safety
(g) Disposal of PMBS
(h) Documenting the quantities recovered and their disposition.

(3) Establish central collection points at HCAs. These activities will accumulate, report, and ship precious metals and PMBS.

f. Each HCA commander will appoint a Precious Metals Coordinator (PMC) to manage an internal PMRP. At the generator level, at least one Precious Metals Monitor (PMM) will be appointed to ensure the recovery of PMBS within the assigned area of responsibility.

g. Each PMM will assign a document number for each turn in of PMBS, based on local HCA procedures.

h. All high purity gold and silver PMBS will be managed as controlled substances. DA Form 3949 (Controlled Substances Record) will be maintained at the user level to record receipt, issues, and turn-in of PMBS except for fixer solution and scrap film.

i. Each MEDDAC/MEDCEN PMC will maintain a DA Form 1296 for each precious metal and PMBS item.

j. The recovery of silver from spent x-ray film developing solutions is an important element of the program; in some cases the costs to comply with applicable environmental regulations can make recovering the silver uneconomical. Activities may use commercial sources for silver recovery as long as these commercial sources comply with applicable Federal, State, and local environmental laws and regulations.

k. Spent fixer solution should not be discharged to the sanitary sewer system, even after silver recovery processing, unless the silver content of the effluent is less than limits prescribed by the Federal, State, and local laws.

3-43. RADIOACTIVE MATERIEL

a. Commanders of HCAs using radioactive materiel will designate, in writing, a radiation safety officer (See *AR 40-14*/*DLAR 1000.28* and *TB MED 525*). This officer will:

(1) Control, receive, issue, store, and dispose of radioactive materiel

(2) Comply with Nuclear Regulatory Commission licenses and Army authorizations

(3) Advise local fire authorities of the type, quantity, and locations of concentrations of radioactive materiel that may pose a hazard in an emergency.

b. The HCA will acquire and control radioactive materiel per *TB MED 525*, *AR 385-11*, *10 Code of Federal Regulations (CFR)*, and the conditions of the activity's NRC license or Department of the Army Radiation Authorization.

3-44. ACCOUNTING FOR IMPLANTABLE MEDICAL DEVICES

a. Implantable medical devices, such as pacemakers, drug infusion pumps, insulin delivery systems, and similar items, will be requisitioned by the using clinical department from the IMSA/MEDLOG Bn/USAMMCE (U. S. Army Medical Materiel Center Europe).

b. DHP funds will be charged for these items regardless of cost. The items will not be accounted for on the activity property book.

c. A record of the requisition, receipt, and implant of the devices will be maintained by the clinical department requesting the item. This record should be in sufficient detail to meet audit requirements and notification of the patient in case of medical device alert or recall by the manufacturer. The patient's medical record must also be annotated with the appropriate data. Essential elements of information include the patient's name; Social Security Number; manufacturer, make, model, and serial number of the device; requisition number; and date implanted.

d. The reporting and tracking requirements of *21 CFR* applies.

3-45. SHIPMENT DISCREPANCIES

a. When shipments received by the IMSA/MEDLOG Bn/USAMMCE are deficient in quantity or condition, the Accountable Officer (or alternate) will inspect the shipment (see the following publications):

AR 55-38
NAVSUPINST 4610.33
AFR 75-18
MCO P4610.19
Defense Logistics Agency Regulation (DLAR) 4500.15
AR 710-2 and *AR 735-11-2*
DLAR 4140.55
Secretary of the Navy Instruction (SECNAVINST) 4355.18
AFR 40-54

b. The manufacturers are only obligated to provide MSDS with the initial shipment of hazardous materials and with the first shipment after an MSDS has been updated. If the MSDS does not accompany a shipment of hazardous materials, the activity must obtain an MSDS from the manufacturer as soon as possible.

c. The PV deficiencies in quantity or condition will be handled per procedures established in the PV statement of work.

d. The IMSA/MEDLOG Bn/USAMMCE will adjust and report any discrepancies. The discrepancy reports most commonly used for medical materiel are:

(1) Standard Form (SF) 361 (Transportation Discrepancy Report; Use this report to report damage or loss attributable to a carrier or improper carrier facilities, and is to be prepared in coordination with the installation transportation office(see the following publications):

AR 55-38
NAVSUPINST 4610.33
AFR 75-18
MCO P4610.19
DLAR 4500.15

(2) The SF 364 [Report of Discrepancy (ROD)]: Use this form to report supply and packaging discrepancies that are obviously the responsibility of the supplier or supporting supply activity(see the following publications):

AR 735-11-2
DLAR 4140.55
SECNAVINST 4355.18
AFR 40-54 and AR 12-12
DLAR 4140.60
SECNAVINST 4355.17A
AFR 67-7

(3) Serious Incident Report: This is used to report theft or suspected theft on high-dollar-value items or controlled substances (see the following publications):

AR 735-11-2
DLAR 4140.55
SECNAVINST 4355.18
AFR 40-54
AR 190-40

e. Distribute copies per the governing regulation.

f. The IMSA/MEDLOG Bn/USAMMCE may request assistance when discrepancies cannot be satisfactorily resolved from:

(1) DSCP,
(2) DLA customer assistance teams, or
(3) The USAMMA.

g. The MTOE medical supply operations will report supply discrepancies to the supporting IMSA/MEDLOG Bn/USAMMCE per local procedures.

3-46. UNSATISFACTORY LOCAL PURCHASE SUPPORT

Reports of local purchase support that adversely affect the health care mission and cannot be resolved within channels should be forwarded through USAMEDCOM to OTSG. The reports should contain:

a. A point of contact (POC)
b. A statement of the problem
c. Actions taken to resolve the problem
d. Applicable documentation.

3-47. EXCESS EQUIPMENT MANAGEMENT PROGRAM

a. The USAMMA manages the Excess Equipment Management Program (EEMP) for the USAMEDCOM. The goals of the EEMP are to:

(1) Ensure timely and cost effective identification of excess equipment.

(2) Eliminate excess medical materiel: Any materiel on-hand and no longer required to satisfy any mission requirement should be considered as excess. Excess materiel must be:

(a) Consumables in condition code "A"
(b) Equipment that is serviceable or economically repairable

(3) Manage excess materiel as a displaced resource that consumes resources and detracts from primary mission accomplishment.

(4) Aggressively report and advertise excess materiel to:

(a) Enhance asset redistribution and use
(b) Reduce disposal requirements

b. The EEMP applies to ARNG, USAR, and all AMEDD activities.

3-48. REPORTABLE AND NONREPORTABLE EXCESS MATERIEL

a. The IMSA/MEDLOG Bn/USAMMCE will report excess materiel through the source of supply. To determine what is excess, the reporting activity must compare current, on-hand materiel with active acquisitions and requirements. The TAMMIS/DMLSS is an automated tool for assisting in this process and recommends materiel to be considered as excess. TDA activities will utilize DMLSS for excess accountability and reporting.

(1) The USAMMA must approve all lateral transfers of equipment greater than the MEDCASE high dollar threshold.

(2) Equipment less than the MEDCASE high-dollar threshold can be laterally transferred without the USAMMA's approval.

b. Reportable non-expendable or expendable excess materiel can fall into one of the following categories:

(1) Non-expendable:

(a) Medical equipment with a line item value that is consistent with current MEDCASE high dollar value threshold.

(b) Serviceable nonstandard medical equipment with a line item dollar value of $2,500 or above.

(c) Regulated medical items identified with AAC "A" in the AMDF or FEDLOG. This includes MESs listed in the *SB 8-75 Series* or critical aeromedical evacuation equipment, such as patient monitors, defibrillators, pulse oximeters, and suction pressure apparatuses.

(d) Medical materiel with recoverability codes “D”, “K”, or “L” regardless of the condition code.

(e) Equipment possessing electrical characteristics unique to a command (220 volts, 50 hertz (HZ)).

(f) Equipment (audiovisual, radioactive, or telecommunications) requiring special disposal procedures.

(g) Automated Data Processing Equipment.

(2) Expendable and durable excess medical materiel:

(a) Standard or nonstandard with a line item value of $500 or more.

(b) Repair parts with a purchase cost of $100 or more.

(c) Compressed gas cylinders (see *AR 700-68/DLAR 4145.25/ NAVSUPINST 4440.128C/MCO 10330.2C/AFR 67-12*).

(d) Aeromedical Evacuation materiel: This materiel could include litters and mattresses, pillows, blankets, litter straps, and patient restraints.

c. The IMSA/MEDLOG Bn/USAMMCE must dispose of or destroy excess materiel not meeting the criteria above. Destruction or disposal can be completed through the use of:

(1) Government awarded pharmaceutical return contracts.

(2) Contracts with other DoD medical facilities.

(3) Contracts with DVA.

(4) Other Government Agencies (National Institute of Health and Public Health Services).

(5) Government awarded disposal contracts.

(6) Supporting Defense Reutilization and Marketing Office (DRMO).

d. The IMSA/MEDLOG Bn/USAMMCE will transfer the excess materiel at no cost to the receiving activity. The shipping cost will be borne by the losing activity.

e. Non-reportable excess materiel follows:

(1) Non-expendable:

(a) Uneconomically repairable equipment with no recoverability code

(b) Equipment where the manufacturer no longer exists

(c) Equipment that lacks a model or part number

(d) Equipment that is no longer made or has exceeded its life expectancy (*TB MED 7* or manufacturer literature)

(e) Equipment with a condition code “F”

(2) Expendable and durable:

(a) Materiel with an expiration date of 3 months or less

(b) Refrigerated and freezer items

(c) Veterinary items.

(3) Miscellaneous materiel:

(a) Medical books and scientific journals (see *AR 40-2*): In OCONUS, MTOE units should turn in obsolete, unserviceable excess medical books to the supporting medical facilities with the appropriate MACOM/Command Surgeon approval. Volumes containing official AMEDD history will be sent to:

Director, Center of Military History
ATTN: DAHM-HM
Washington DC 20314-0200

(b) Radioactive materiel (see *AR 385-11*)

(c) Flags and Guidons (see *AR 840-10*).

3-49. REPORTING EXCESS

a. The IMSA/MEDLOG Bn/USAMMCE must report any reportable excess materiel monthly in the form of a manual or automated report. The *AR 725-50* prescribes the codes for the automated report.

b. The RMC/MSCs will establish manual reporting procedures for non-expendable and expendable excess materiel within their command. The USAMMA will establish manual reporting procedures for the USARC, ARNG, CONUS, and OCONUS activities not supported by an RMC.

(1) Examples of manual reporting procedures for non-expendable materiel follow:

(a) For regulated medical items to include MES, include the set control code, estimated dollar value or shortages, and a statement of the set's condition. Aeromedical evacuation materiel and equipment is reported per procedures in *AR 40-538*/ Department of the *Navy Bureau of Medicine and Surgery Instruction (BUMEDINST) 6700.2B/AFR 167-5*.

(b) For equipment requiring special disposal procedures, report through the commodities NICP or the responsible governing agency.

(2) The RMC/MSCs will establish manual reporting procedures for expendable materiel. One category of expendable materiel requiring specific reporting is compressed gas cylinders. These cylinders should be reported for turn-in by using the NSN of an unserviceable (empty) cylinder.

c. The AMEDD TDA activities will use DMLSS ETM to report non-expendable equipment. Activities using DMLSS ETM will report equipment excess in accordance with the procedures outlined in Chapter 5, Para 5-9b. The MTOE units will follow guidance from either their MACOM or the USAMMA when using the Standard Property Book System - Redesign. The MTOE can only generate excess non-expendable equipment through a change of the MTOE authorization document, fielding plans, and/or deployment/contingency.

(1) The Property Book Officer (PBO), when using DMLSS ETM, will establish excess property records for reportable excess equipment. The USAMMA coordinates the report of excess equipment worldwide for redistribution.

(2) Automation equipment requires specific automated reporting procedures (see *AR 25-1*). The AMEDD activities will establish an Automation Resources Management Systems account with the Defense Automation Resources Management Program to report excess automation equipment per *DoD 7950.1M*.

d. The RMC/MSC will require the following information on manual or automated excess reports:

(1) Nomenclature, make, and model number
(2) NSN, if assigned
(3) Date placed in service
(4) Quantity
(5) Line item dollar value
(6) Condition code
(7) Local point of contact

3-50. QUARTERLY EXCESS REPORT TO THE USAMMA

The RMC/MSCs will report the excess equipment/materiel redistributed through the EEMP to the USAMMA on a quarterly basis. This consolidated excess report is due no later than the 20th of January, April, July, and October of each year. Figure 3-1 shows the proper format for the RMC/MSC consolidated excess report.

QUARTERLY REDISTRIBUTED EXCESS EQUIPMENT/MATERIEL REPORT	
Date Prepared _____	
Value of reported excess equipment	$_____
Value of redistributed excess equipment	$_____
Distribution of excess equipment/materiel:	$_____
Within the RMC/MSC	$_____
Outside the RMC/MSC	$_____
Through DRMO to Other Activities	$_____
To Department of Labor, state, or local facilities	$_____
To USAR or ARNG	$_____
Value of redistributed excess equipment equal to or greater than current MEDCASE high dollar value	$_____
Value of redistributed excess equipment not advertised	$_____
Value of excess equipment turned in to DRMO not listed on excess report	$_____
Value of excess equipment turned in to DRMO and listed on excess report	$_____
Total dollar amount of excess equipment turned in to DRMO	$_____

Figure 3-1. Format of the Quarterly Distributed Excess Equipment/Materiel Report

3-51. ADVERTISING EXCESS

a. The RMC/MSC will establish advertising procedures within their health care boundaries for excess equipment and materiel. The RMC/MSC will consolidate and screen all excess reports from their supporting activities. The RMC/MSC will satisfy any requirement within the command during the screening process.

b. The RMC/MSCs will advertise excess materiel distributed throughout the command for no longer than 15 calendar days. If an organization outside of the RMC/MSC command boundaries requests an item on the advertised excess list, the RMC/MSC must request an exception to the redistribution priority scheme from the USAMMA. Lateral transfer procedures will apply (see *AR 710-2*). After the 15-day period, RMC/MSC will submit the consolidated excess materiel report to the USAMMA.

c. The USAMMA will consolidate the excess reports from the RMC/MSCs. The consolidated excess report will be distributed worldwide for advertisement purposes via message format and the USAMMA home page. After the 30-day advertisement period, the IMSA/MEDLOG Bn/USAMMCE can process the unclaimed, unwanted equipment or materiel through the DRMO.

3-52. REDISTRIBUTING EXCESS

a. The USAMMA manages excess equipment/materiel redistribution Army wide. The USAMMA will follow the sequence below to redistribute assets:

- USAMEDCOM
- Other MACOMs
- DoD activities

- Other Federal agencies
- Local redevelopment authority
- DRMO

b. The **losing** activity will:

(1) Notify the gaining activity of the transfer arrangements.

(2) Complete all necessary documentation per *AR 710-2* to facilitate the transfer.

(3) Ensure that appropriate maintenance personnel technically inspect the equipment to be transferred. A DA Form 2407 will be completed and sent with the equipment.

(4) Ensure equipment is properly packed, crated and shipped per *AR 746-1*. The following must accompany the shipped equipment:

(a) Supporting supplies (expendables) and accessories

(b) Repair parts and listing

(c) Operator and technical manuals and manufacturer literature

(d) The maintenance history/records, to include the DA Form 2407.

(5) Receive a signed copy of the completed lateral transfer document.

(6) Notify the Resource Management Office to have the LIN deleted from the TDA, if applicable.

(7) Delete the property record.

(8) Maintain the lateral transfer documentation for two years.

c. The **gaining** activity will:

(1) Notify the USAMMA of the requirement for excess equipment/materiel.

(2) Arrange the transfer with losing activity's point of contact.

(3) Upon receipt of the excess equipment:

(a) Inspect transferred equipment for damage and resolve discrepancies with the losing activity. If improper packaging is suspected, notify the USAMMA.

(b) Sign and return a copy of the lateral transfer document to the losing activity within 3 days.

(4) Establish a property book record within 3 days of receipt.

(5) Submit DA Form 2028 (Recommended Changes to Publications and Blank Forms) to their Resource Management Office to add the LIN to the TDA, if applicable.

(6) Maintain accountability for the transferred equipment throughout its life cycle.

3-53. DISPOSAL THROUGH DRMO

a. The IMSA/MEDLOG Bn/USAMMCE will manage medical materiel turn in from installation and area activities to the DRMO. Other medical supply operations will turn-in materiel through the IMSA/MEDLOG Bn/USAMMCE to the DRMO. The IMSA/MEDLOG Bns/USAMMCE will establish local procedures to minimize redundant storage and handling of turn-in materiel. When conditions permit, PBOs may establish equipment turn-in procedures directly to the DRMO, without physically moving the items through the IMSA/MEDLOG Bn/USAMMCE storage facility. The IMSA/MEDLOG Bn/USAMMCE must approve these procedures. The IMSA/MEDLOG Bn/USAMMCE should process and approve documentation for materiel turn in with condition codes that indicate a continued value to the government. This materiel will move directly from the unit to the DRMO. The PBO may turn in medical equipment with condition codes "H" and "S" directly to the DRMO. The IMSA/MEDLOG Bn/USAMMCE will:

(1) Report the materiel turn-in to the DRMO

(2) Provide technical assistance to the DRMO as required

b. The DRMO will process materiel requiring special handling as follows:

(1) Medical materiel that is unserviceable, uneconomically repairable, or otherwise unsuitable for use will be marked

"**CONDEMNED - NOT FOR PATIENT CARE**"

Medical materiel determined to be hazardous, where the hazardous condition cannot be repaired, will be clearly marked and tagged to state the nature of the hazard. This marking will render the materiel unusable for its intended purpose before turn-in.

(2) Serviceable stock/materiel with lot or batch numbers and an acquisition cost of $500 or more per lot or batch number will be processed according to *DoD 4160.21-M*. Examples are as follows:

(a) The FSC 6505 - Drugs, Biologicals and Reagents (excluding filled gas cylinders) will **not** be disposed through the DRMO. The IMSA/MEDLOG Bn/USAMMCE may request DRMO assistance in reutilization or donation of non-controlled, non-hazardous drugs following the procedures outlined in *DoD 4160.21-M*

(b) The FSC 6510 - Surgical Dressing Materiel

(c) The FSC 6515 - Sutures Only

(3) Compressed gas cylinders will be prepared for turn-in as prescribed in *AR 700-68/DLAR 4145.25/NAVSUPINST 4440.128C/MCO 10330.2C/ AFR 67-12*, prior to transfer to the DRMO. As an alternative, IMSA/MEDLOG Bn/USAMMCE may contract for gas cylinder disposal with vendors who are licensed in accordance with Federal, State, and local laws.

(4) The IMSA/MEDLOG Bn/USAMMCE will retain physical custody of standard and nonstandard pilferable items listed below until disposition instructions are provided by the DRMO.

- Medical items containing recoverable amounts of precious metals. The IMSA/MEDLOG Bn/USAMMCE should precisely mark the items so that disposal personnel may take special handling precautions (see *DoD 4160.21-M*). Standard pilferable items are identified as Note “M” in the FSC and as Recoverability Code “A” in the AMDF or FEDLOG.
- Standard precious metals. These are identified as Note “R” in the Federal Supply Catalog.
- Tax-free alcohol and serviceable hypodermic needles and syringes: Clearly identify before transferring to the DRMO to ensure special processing (see *DoD 4160.21-M).*

(5) Unexposed medical and dental film, which is not expired, will be disposed through the precious metals recovery program.

c. The MACOM/Command Surgeons will establish property disposal policies and procedures based on local command and DRMO procedures and the above guidelines.

d. Medical materiel eligible for disposal may be designated for training with the HCA commander’s approval. Items approved for training use will be clearly identified with a “FOR TRAINING ONLY” label to prevent accidental use on actual patients. Medical personnel must ensure that approved training materiel has been properly disposed after the training mission. Expired drugs, biologicals, intravenous solutions, and reagents may be used for training purposes.

e. To prevent needed medical materiel from being transferred or disposed prematurely, obtain professional guidance from outside Logistics Division, e.g., pharmacy, pathology/ laboratory, radiology departments, as to the materiel’s further or potential use.

3-54. DISPOSITION AND REPLACEMENT CREDITS FOR EXPIRED DRUGS, BIOLOGICALS, AND REAGENTS

a. The MTF/IMSA/MEDLOG Bn/USAMMCE can use pharmaceutical returns contracts for expired drugs and biologicals. These contracts are with companies generically called ‘Reverse Distributors’ who remove expired drugs and biologicals from an activity and obtain credits from pharmaceutical manufacturers for these unserviceable products. The reverse distributors then return the credits to the DSCP Pharmaceutical PV which the activity can use for the procurement of new pharmaceuticals. Accumulated credits will be used within 90 days in accordance with the Defense Logistics Agency (DLA) memorandum, DSCP-GM, 31 July 2000, subject: Pharmaceutical Returns Management Program. For pharmaceuticals where no credits

can be obtained, the company must destroy the unserviceable materiel per Federal, state, and local laws.

b. The DSCP and Department of Veterans Affairs (DVA) have partnered in a national contract (SPO200-05-R-1608) with six reverse distributors: EXP Pharmaceutical Services, Genco Infrastructure, Guaranteed Returns, Pharma Logistics, Stericycle Inc and SY Science for processing expired pharmaceuticals. Activities are required to use this mandatory contract. The website below has the DSCP online enrollment procedure and the contract information that can be downloaded: https://dmmonline.dscp.dla.mil/pharm/reversedistribution.asp

c. The Chief of Logistics and the Chief of Pharmacy will ensure expired pharmaceuticals are handled in an accountable process with procedures in place to track and obtain maximum credit for an activity, and to ensure the pharmaceuticals are properly dispose of in accordance with all applicable federal, state, and local regulations.

d. The contractor must fully document the disposal of all pharmaceuticals and provide the activity with that documentation. The contractor will provide the activity with at least quarterly credit reports for the returned drugs showing the status of the disposed pharmaceuticals. If a contractor representative goes to a facility to assist in preparing expired drugs for shipment, they are required by law to provide a detail inventory of all Schedule II drugs before leaving the facility.

e. The activities DSCP Pharmaceutical PV Contracting Officers Representative (COR) will serve as the activities COR for the reverse distributor contract.

3-55. CUSTOM ARMY REPORTING SYSTEM (CARS)

a. The AMEDD is required by DoD to significantly reduce non-productive expenses (interest penalties) for cost savings across the AMEDD. The U.S. Army MEDCOM Chief of Staff will monitor interest payments for reductions by RMC/MSC during quarterly Command Management Reviews.

b. Delinquent receiving reports over 30 days are incurring costly interest penalties to MEDCOM. The Assistant Chief of Staff for Logistics (ACSLOG) goal is to ensure those Personnel who are responsible for completing receiving reports provide them to Vendor Pay Offices within five working days of delivery or completion of services in accordance with *DFAS-IN 37-090102F*. Meeting this goal can be best accomplished through electronic submission of invoices and receiving reports in WAWF–Receipt and Acceptance (WAWF-RA).

c. Assistant Chief of Staff for Resource Management (ACSRM), Finance and Accounting Office (F&AO) developed a web-based program that allows activities to monitor contract payments. The CARS program tracks financial transactions within the DFAS. The program extracts data almost daily from the DFAS-SA Commercial Accounting and Payment System Worldwide (CAPS-W), which provides payment status on contracts.

d. Logistics Divisions will monitor their contracts using the CARS tool as often as required or at least monthly to prevent aged invoices from accumulating interest penalties. All Invoices 15 days and older are of particular concerned; these require immediate attention and must be worked. Contract payment information can be reviewed by installation name, DODAAC and Allotment Serial Number (ASN).

e. The CARS report is located on the MEDCOM ACSRM website at http://www.medcomrm.amedd.army.mil. The instructions below will assist in assessing the report.

(1) At the website, select "Finance & Accounting" tab from the menu on the left and select Home Page.

(2) From the menu select Vendor Pay/WAWF (Wide Area Work Flow).

(3) Click on "CARS Report" from the drop-down menu, select "Save", and save the file under your "Desktop". When prompted close the dialog box and exit out of the website.

(4) On your "Desktop" click on the cars.exe icon and select Run in the dialog box. Click unzip to save database files to default location C:\CARS, select "OK" and close to exit zip program.

(5) Data can be retrieved in several ways. The recommended procedures for data retrieval is to access "My Computer", go to the "C" drive and open the CARS folder and double-click the **CarsNG.MDE** file. The file may also be retrieved by opening the Microsoft ACCESS CARS Program, double-click on "more files" and select the C drive in the "look-in" window. Double-click the CARS folder then open the **CarsNG.MDE** file to execute the program.

(6) The "main menu" screen will open to view "Invoices without Rec. Reports". Six icons are available; choose the first icon (Invoice Details). Go to the "Filter By" dialog box and click on "DODAAC" to find a specific activity. Choose the DODAAC from the drop down menu and select "Run that Puppy" to run the query. Review the report for the Element of Resources (EOR) 26 and 31 (supplies and equipment) to determine current billing status at DFAS-SA for any pending receiving reports or outstanding invoices.

f. Logistics Division reviewing/submitting receiving reports must pay close attention to the received date, projected interest amount, and the EOR column. The received date column is the date DFAS received the vendor's invoice and alerts the activity to submit their receiving report to DFAS. The projected interest amount column represents the projected interest amount payable on the **Amount Clin** column. Interest penalties begin to accrue when invoices are overdue 30-days.

3-56. WIDE AREA WORKFLOW – RECEIPTS AND ACCEPTANCE

a. All MEDCOM activities are required to utilize the DoD e-commerce initiative, WAWF-RA, for contractual goods and services not purchased by credit card or convenience check. This initiative, which uses existing systems compliant with the Prompt Payment Act, will decrease interest penalties. The DoD paperless contracting initiative was created in response to the DoD Comptroller Management Reform Memorandum #2, 21 May 1997, "Moving to a Paper-free Contracting Process by January 1, 2000".

b. The WAWF-RA enables vendors and government officials to electronically access and process the documentation to generate payment for goods and services. This is done by utilizing contracts, invoices and receiving reports within a web-based system.

c. The WAWF-RA offers important benefits to the Logistics, Resource Management and Finance communities.

(1) Users have global access to basic and supporting documents to reduce the need for re-keying, improve accuracy, and provide real-time processing with access to documents status. Users will no longer handwrite information, manually fax, or mail forms to DFAS.

(2) Users have instant visibility of contracts, thus eliminating the 5-day waiting period required by Contracting to forward paper documents and complete receiving reports. The DFAS will have all documentation required to pay vendors, which minimizes late interest penalties.

d. The Chief of Logistics' key role in WAWF-RA implementation is to ensure receiving reports are promptly signed and submitted electronically IAW *DFARS, Appendix F-401* standards. The following guidelines are provided:

(1) Activities will operate only at the assigned basic DODAAC address level. Activities utilizing extensions, Accounting Processing Code (APC), dummy DODAAC, or equivalent will be dropped from WAWF.

(2) Activities receiving goods and services must record the receipts upon delivery or completion of services. Medical Maintenance and Property Management will ensure they receive and process receipts prior to completing technical inspections, calibration, or equipment system tests.

(3) Commercial items and services are not subject to extended acceptance periods. The inspection and acceptance process must be completed within five working days unless contract specifications state otherwise.

(4) Activities will forward receiving reports to the designated DFAS by the fifth working day after acceptance, or as otherwise specified in the contract.

e. Designated Logistics personnel will have their computers configured with WAWF-RA and will then complete the DD Form 2875, System Authorization Access Request Form, available at https://wawf.eb.mil. Submit the DISA form and then self-register at the site. Users are highly encouraged to register with the Electronic Document Access located at http://eda.ogden.disa.mil. This site has valuable information on validating receiving report data, vendor invoice data, contract numbers, and other important data field information.

f. Additional information on WAWF-RA e-commerce is available at https://wawf.eb.mil. The website contains information such as Web-based T raining, Active DODAACs and Roles, Frequently Asked Questions, DD Form 2875, and Policies and Procedures for Submitting Receiving Reports. Utilization of WAWF-RA is a Command Logistics Review Program item, and activities will be inspected for compliance.

3-57. FUNDING LOCAL PURCHASES

a. DHP funds to finance local purchase of nonstocked medical supplies and equipment items.

b. For equipment funded through MEDCASE, follow procurement procedures in *SB 8-75-MEDCASE*.

3-58. DEFENSE ATTACHÉ MEDICAL SUPPLY SUPPORT

Medical funds available to the command will finance medical supplies issued pursuant to this section unless different billing arrangements have been made.

a. Army personnel serving, as Defense Attachés will use local supply sources or HCA located within a reasonable distance.

b. Major OCONUS Commanders will provide medical supply support upon request if:

(1) The personnel are stationed within the command's area of support.

(2) Communications and transportation permit: Examples of communication and transportation that may be available are State Department pouch, U.S. Military Post Office, or Embassy Post Office.

c. Commander, Walter Reed Army Medical Center (WRAMC):

(1) Provides medical supply support where other sources are not available or where difficulties exist in communications.

(2) Designates the U.S Army Health Clinic, Pentagon, as a supply source. Forward requests for medical supplies through the Army's Assistant Chief of Staff for Intelligence to the U.S. Army Health Clinic, Pentagon. Normally, this supply action is limited to delivery by State Department pouch.

d. Prescription-type items will be dispensed from a pharmacy when a doctor's prescription is presented, per *AR 40-2*.

e. Requests for exception to this procedure will be forwarded to USAMEDCOM, ATTN: MCLO-O, Fort Sam Houston, TX 78234.

3-59. RENOVATION OF HEALTH CARE FACILITIES

a. Obtain equipment and furnishings needed to support Medical Military Construction (MILCON) projects by using MEDCASE procedures (see the 2004 edition of the *SB 8-75-MEDCASE*).

b. Use GSA or commercial interior design services to determine entire furnishing requirements and design decor when renovating entire offices or areas. Fund design services from local operating funds.

3-60. REVIEW PROGRAM FOR DURABLE MEDICAL MATERIEL

a. The HCA Commanders/Command Surgeons establish a formal program for reviewing the consumption of durable medical materiel. This program is designed to:

(1) Improve supply discipline
(2) Emphasize economy
(3) Monitor usage
(4) Focus attention on the prudent use of durable medical materiel.

b. To manage the program, commanders must conduct semi-annual consumption reviews. The review should include the 20 durable medical materiel items where the activity experienced the greatest expenditure during the last year. During the semi-annual review, Commanders should focus attention on increased usage and potential savings for the activity. MTF reviews are to focus on internal hospital consumption of durable items as demands for external customers are beyond their control. Reviews may also be conducted on the remaining durable medical materiel items for which the activity desires control visibility, such as items experiencing a high loss rate. From this review, items will be selected for intensive management and will be managed as stated below (see para c and d). The ARNG activities will conduct annual reviews.

c. Durable medical materiel selected for intensive management may be managed as turn-in and direct exchange items. If an unserviceable item is not available for exchange, the IMSA/MEDLOG Bn/USAMMCE justifying the items can require a letter or form.

d. Usage levels can be established for the organization and for individual customers. Actual usage should be reviewed against established usage levels. Activities will document the review to include corrective action taken or the cause(s) for usage in excess of the established rate. These reviews will be maintained according to *AR 25-400-2*.

e. The MTOE units normally will not establish usage levels unless actively engaged in patient care.

f. Activities will dispose of uneconomically repairable durable medical materiel items through their IMSA/MEDLOG Bn/USAMMCE to the DRMO.

3-61. GOVERNMENT PURCHASE CARD (GPC) PROGRAM

a. Monthly reconciliation process for Defense Health Program (DHP) and Defense Working Capital Fund (DWCF) Funded Activities

(1) The Access Online (AXOL) tool is the new U.S. Bank's electronic access system that replaces the Customer Automation and Reporting Environment tool (C.A.R.E.), which allows review of transactions and electronic payments for purchase card purchases. The U.S. Bank GPC billing cycle ends on the 19th of each month. Approving Officials (AOs) have five business days from the end of the billing cycle to reconcile their GPC Accounts but NLT the 28th of the statement month. AXOL Purchase Card Quick Reference Guide is posted on

https://www.medlogspt.army.mil/MedcomLogistics/CMedLogWeb/Sections/Op_Mgt_Div/Logistics_OMD_Reports.htm.

(2) The DMLSS purchase card reconciliation process is mandatory for both DHP and DWCF sites. The AOs have five business days from the end of the U.S. Bank GPC billing cycle to reconcile their DMLSS account but NLT the 28th of the statement month. DMLSS Purchase Card Reconciliation Guide is posted on https://www.medlogspt.army.mil/MedcomLogistics/CMedLogWeb/Sections/Op_Mgt_Div/Logistics_OMD_Reports.htm.

(3) Activities currently using the C.A.R.E. as the U.S. Bank's communication tool, the AOs have five business days from the end of the billing cycle to reconcile their GPC Accounts but NLT the 28th of the statement month. C.A.R.E. Purchase Card Reconciliation Manual is posted on https://www.medlogspt.army.mil/MedcomLogistics/CMedLogWeb/Sections/Op_Mgt_Div/Logistics_OMD_Reports.htm.

b. The AXOL electronic printed statement will list all purchases for audit/oversight. The AXOL printed statement along with receipts will document approvals for purchases IAW the FAR/DFARS/AFARs. For more information about AXOL, review the website at https://wbt.access.usbank.com.

c. The DMLSS Purchase Card Register provides line item detail for complete visibility and allows AOs the capability to view cardholder's purchases. AOs can monitor unauthorized, erroneous or questionable purchases to ensure compliance with the DA Government Purchase Card Regulation, *AR 715-xx*. The DD1155 form that is printed from DMLSS will be maintained with other supporting documentation to validate purchases are entered into DMLSS. For more information about DMLSS, review the website at www.medlogspt.army.mil. The information is located on the DMLSS E-Learning link.

d. The C.A.R.E. electronic printed statement will list all purchases for audit/oversight. The C.A.R.E. printed statement along with receipts will document approvals for purchases IAW the FAR/DFARS/AFARs. For more information about C.A.R.E, review the website at https://wbt.care.usbank.com

3-62. AUTOMATED FINANCIAL AND COMMAND MANAGEMENT REVIEW AND MANAGEMENT REPORTS FOR DHP AND DWCF ACTIVITIES

a. The following procedures outline the requirement for submittal of the management reports in support of the Command Management Review (CMR) and other management requirements for DHP and DWCF activities. The overarching goal is to minimize and standardize the electronic submittal of financial and management reports and eliminate hard copy submittals via facsimile.

b. Activities should review these reports to assess their position and performance toward MEDCOM goals and management objectives. This allows for corrective actions to effect change before quarterly updates to TSG.

c. DMLSS reports will be e-mailed in Excel format using the "DHP Funded Activities" or the "DWCF Funded Activities" workbook (as applicable) posted at https://www.medlogspt.army.mil/MedcomLogistics/CMedLogWeb/Sections/Op_Mgt_Div/Logistics_OMD_Reports.htm under the Periodic Reports Header.

d. TAMMIS reports will be e-mailed in txt format, and will be submitted for Fund Owner (FO) Code 2. DMLSS and TAMMIS reports are due to MEDCOM by the 10th of the month for the preceding month. This gives activities time to post and reconcile the data (Purchase Card etc.). Submit all reports in accordance with your RMC instructions for ultimate submittal to MEDCOM.

e. DMLSS reports required monthly are (all in Excel format):
(1) Refundable Items Sales Rollup.
(2) Receipt By Supplier Type.
(3) MEDCOM R&A IM Roll-up (the ERMC format ERMC activities).
(4) Prime Vendor Fill Rate (for PVP and PVM by Call Number Seq.) [not required from ERMC MEDDACs].
(5) Stock Status (Summary).
(6) IM Dashboard.
(7) Balance of Obligation Authority/DLA Stock Fund Target Report (DWCF activities only).
(8) Summary Total of the Monthly Purchase Card Bank Statement(s) (DWCF activities only).

f. TAMMIS reports required monthly are (all in Txt format):
(1) Balance of Obligation Authority Report (PCN: RZS-SWC).
(2) Transaction Summary Totals (PCN: RZS-SA2).
(3) Stock Status Summary Recap (PCN: RZS-SA3).
(4) MEDCOM CMR Report.
(5) Fill Rate Report by Source of Supply (Select your primary PV).
(6) Summary Total of the Monthly Purchase Card Bank Statement(s).

g. DMLSS reports must be run on or after the 1st of the month for the prior month. Please make sure the latest versions of the Business Objects reports are used as posted at the above referenced Web Site. The resultant Excel workbook must be submitted in accordance with your RMC instructions and must reach MEDCOM NLT Close of Business (COB) the 10th of the month. DMLSS activity step-by-steps (use the applicable DHP or DWCF Funded Activity Excel workbook):

(1) Refundable Items Sales Report.
(a) From IM open Business Objects
(b) Open Refundable Items Sales Report
(c) Refresh the report and select the applicable date range
(d) Click on the Refundable Items Sales Roll-up report tab
(e) From the Edit drop down menu select "Copy All"
(f) Open the Excel workbook at the appropriate tab and right click in the first cell (A1)
(g) Select Paste from the speed menu

(2) Receipt by Supplier Type Report.
(a) In DMLSS IM click on REPORTS icon (top tool bar).
(b) Click the desired report (Receipt by Supplier).
(c) Select the report to run for IM
(d) Enter the appropriate date-range (month).
(e) From the right edge toolbar select “Save to File”.
(f) From the “Save to file” screen select Desktop from the drop down of the “Save to File” section
(g) Select Excel Files (*.XLS) as the “Save as Type”.
(h) Name the file “Receipt by Supplier Type”.
(i) Once saved on your desk top, open that report and highlight and copy the data.
(j) Open the Excel workbook at the appropriate tab and right click in the first cell (A1)
(k) Select Paste from the speed menu.

(3) MEDCOM R&A Report (IM Roll-up).
(a) In DMLSS select Business Objects.
(b) Select Material Management option.
(c) Launch Business Objects.
(d) Open Business Objects report (MEDCOM R&A IM Roll Up).

(e) When report opens click on the refresh data button.
(f) Enter the beginning and ending dates (first and last day of the month) when prompted and click OK.
(g) From the Edit drop down menu select "Copy All".
(h) Open the Excel workbook at the appropriate tab and right click in the first cell (A1).
(i) Select Paste from the speed menu.

(4) Prime Vendor Fill Rate (source of Supply: PVP & PVM), Not required from ERMC MEDDACs.
(a) Open standard reports in IM and select Prime vendor Fill Rate report.
(b) Double click on highlighted line or click on view.
(c) Select primary source of supply (both PVP & PVM), specify month as applicable, select summary report and show by call number, click on OK.
(d) From the right edge toolbar select “Save to File”.
(e) From the “Save to file” screen select Desktop from the drop down of the “Save to File” section
(f) Select Excel Files (*.XLS) as the “Save as Type”.
(g) Name the file Stock “Prime Vendor Fill Rate”.
(h) Once saved on your desk top, open that report and highlight and copy the data.
(i) Open the Excel workbook at the appropriate tab and right click in the first cell (A1)
(j) Select Paste from the speed menu.

(5) Stock Status Report.
(a) In DMLSS IM click on REPORTS icon (top tool bar).
(b) Click the desired report (Stock Status).
(c) Select the Summary report (Note: do not select management notices, this is for detail report only).
(d) From the right edge toolbar select “Save to File”.
(e) From the “Save to file” screen select Desktop from the drop down of the “Save to File” section
(f) Select Excel Files (*.XLS) as the “Save as Type”.
(g) Name the file “Stock Status”.
(h) Once saved on your desk top, open that report and highlight and copy the data.
(i) Open the Excel workbook at the appropriate tab and right click in the first cell (A1)
(j) Select Paste from the speed menu.

(6) IM Dashboard Report
(a) Go into IM and select Utilities from the top tool bar.
(b) From the drop down menu select Dashboard.
(c) From the top toolbar select the save Icon.
(d) From the “Save as” screen select Desktop from the drop down of the “Save to in” section
(e) Keep the default “Save As” and “File Name of “Dashboard Summary”.
(f) Once saved on your desk top, open that report and highlight and copy the data.
(g) Open the Excel workbook at the appropriate tab and right click in the first cell (A1).
(h) Select Paste from the speed menu.

(7) (DWCF Funded Activities only) Balance of Obligation Authority DWCF Report.
(a) Prior to running this report ensure the Purchase Card(s)/Bank Statement(s) are reconciled in DMLSS through and including the prior month.

(b) In DMLSS select Business Objects (BO).
(c) Select Materiel management.
(d) From the BO standard report viewer select Balance of Obligation Authority DWCF Report and open report.
(e) Once the report opens it prompts for FY, enter the applicable FY as YYYY format and click OK.
(f) From the Edit drop down menu select "Copy All"
(g) Open the Excel workbook at the appropriate tab and right click in the first cell (A1).
(h) Select Paste from the speed menu.

(8) (DWCF Funded Activities only) Summary DWCF Credit Card Statement(s): At the end of the Billing Cycle and upon receipt of the Bank Statement, record the summed total of charges for (all) Purchase Card(s) at the appropriate tab of the Excel Workbook.

h. TAMMIS reports must be run on or after the 1st of the month for the prior month. The resultant reports must be submitted so as to reach MEDCOM NLT COB the 10th of the month. TAMMIS activity step-by-steps:

(1) Balance of Obligation Authority Report (PCN: RZS-SWC).
(a) In TAMMIS MEDSUP execute menu item 5.5 Archive Log Maintenance.
(b) Press [F1] Go Query.
(c) Cursor to the Comment field (second line) and enter RZS-SWC.
(d) Press [F1] Do Query and TAMMIS will locate all of the RZS-SWC, Balance of Obligation Authority Reports.
(e) Press [F6] Send File for the report dated for the month being submitted.
(f) Select DOS 3.5 HD Diskette. Ensure there is a DOS Diskette in the HP-9000 disk drive. Press [F1] Send File.
(g) Take the diskette to your desk and attach the files to e-mail to MEDCOM.
(h) Include in the e-mail message any memo entries for credit card (e.g. unbilled receipts total, statement amount not included in rollups).

(2) Transaction Summary Totals (PCN: RZS-SA2) and Stock Status Summary Recap (PCN:RZS-SA3). These reports are part of the overall Stock Status Summary 5 Operations Management Bulletin No. 03-06 (RZS-SA1). Activities may send the entire report if users are unable to isolate and extract these portions of the report.
(a) In TAMMIS MEDSUP execute menu item 5.5 Archive Log Maintenance.
(b) Press [F1] Go Query.
(c) Cursor to the comment field (second line) and enter RZS-SA1.
(d) Press [F1] Do Query and TAMMIS will locate all of the RZS-SA1, Stock Status Summary.
(e) Press [F6] Send File for the report dated for the month being submitted.
(f) Select DOS 3.5 HD Diskette. Ensure there is a DOS Diskette in the HP-9000 disk drive. Press [F1] Send File.
(g) Load the diskette into your computer's A: drive and attach the Stock Status Summary files to e-mail and submit to MEDCOM.

(3) MEDCOM R&A Report.
(a) In TAMMIS MEDSUP execute menu item 3.6.7 Generate MEDCOM R&A Data. Enter the dates (DD/MM/YY) for the applicable month.
(b) Press [F1] Send File. The file will be generated and the system will say that the file has been sent.

(c) In TAMMIS MEDSUP execute menu item 5.5 Archive Log Maintenance.
(d) Find the MEDCOM R&A Data file.
(e) Press [F6] Send File.
(f) Select DOS 3.5 HD Diskette. Ensure there is a DOS Diskette in the HP-9000 disk drive. Press [F1] Send File.
(g) Take the diskette to your desktop PC and attach the file to e-mail to MEDCOM.

(4) d. Fill Rate report by Source of Supply.
(a) Login into DMLSS and click on the Prime vender interface option.
(b) Click on the reports icon.
(c) Highlight Fill Rate report by SOS and click on the view icon. Select your Med/Surg prime vendor.
(d) Fill in the criteria for report by selecting Legacy Org Name, SOS Name, from and to dates and click on the Ok button.
(e) Click on the save icon and save report as an Excel file and e-mail to MEDCOM ASCLOG.

3-63. MEASURING MEDICAL SUPPLY PERFORMANCE

Paragraphs 3-64 through 3-67 provide formulas for computing medical supply performance standards (in addition to those outlined in *AR 710-2*).

3-64. MEASURING CUSTOMER SUPPORT

a. Demand satisfaction: Demand satisfaction represents the percentage of demands for stocked lines satisfied by 100 percent of the total quantity demanded. Used the formula shown below to compute this figure:

(1) Formula:

$$\frac{\text{Valid Demands for Stocked Items 100\% Filled}}{\text{Total Valid Demands for Stocked Items Received}} \times 100 = \text{Demand Satisfaction Stocked Items Satisfied by 100\%}$$

(2) Example: 6,378 of 6,700 total demands for stocked items were 100 percent filled.

$$\frac{6{,}378}{6{,}700} \times 100 = 95\%$$

b. Performance measures are as follows:
(1) Management objective: 95 percent
(2) Management level 90 to 98 percent

c. Indicate the adequacy of RO levels; that is, whether stockage quantities are sufficient considering OST and fluctuating demands.

d. May indicate, if extremely high, that stock levels are too high. If demand satisfaction is low, examine the following items:
(1) Zero-balance rate.
(2) Receipt processing time.
(3) Validity of OST quantities based on recent experience.

3-65. MEASURING INVENTORY MANAGEMENT

a. Zero balance rate (percentage out of stock).

(1) The zero balance rate indicates the percentage of stocked lines that are at zero balance.

- It is an indicator of inventory management effectiveness and is usually related to demand satisfaction.
- It's a measurement that detects inventory management problems earlier than other indicators.
- It gives a rapid general picture of inventory status for RO/level (demand supported) stocked lines at a given point in time.

Potential problems highlighted by this indicator may not have been discovered with other indicators, because the system deficiency may have occurred only recently. For example, if a series of requisitions to a supply source had been lost or if transportation breakdowns had frustrated one or more shipments, this measure would quickly reflect either problem. Only later would these same problems also affect the demand satisfaction. A very low zero balance rate may reflect significant improvements in the resupply system, improvements in transportation support to the IMSA, or a significant downturn in customer demands.

(2) Formula:

$$\frac{\text{Number of Stocked Lines at Zero Balance with an Established Due - Out}}{\text{Number of Stocked Lines}} \times 100 = \text{Zero Balance Rate}$$

(3) Example: If there are 70 stocked lines at zero balance out of a total of 1,578 stocked lines, then:

$$\frac{70}{1{,}578} \times 100 = 4\%$$

(4) Performance measures are as follows:

(a) Management objective: less than 5 percent.

(b) Management level: 2 to 8 percent.

b. Issue Priority Designator (IPD) high priority request/requisition rates.

(1) This rate indicates the percentage of all requisitions placed upon a supply source (either local procurement or the DLA supply system) that have an IPD of 01-08 (exclude life or death IPD 03 requisitions from all calculations).

(2) Use the formula below for computing these rates.

(a) Formula:

$$\frac{\text{IPD 01 to 08 Requests/Requisitions}}{\text{Total Requests or Requisitions}} \times 100 = \text{IPD Request/Requisition Rate}$$

(b) Example: If there are 17 IPD 01 through 08 requests/requisitions out of 189 total requests or requisitions submitted,

$$\frac{17}{189} \times 100 = 9\%$$

(3) Performance measures are as follows:

(a) Management objective: Less than 20 percent.

(b) Management level: None.

(4) Excessive use of high IPDs is symptomatic of a variety of potential problems but may, infrequently, be totally reasonable and necessary. Routine use of IPDs 01 through 08 indicates the following:

(a) Basic data believed reliable in establishing OST values may not be valid.

(b) Proper materiel is not stocked.

(c) Customers require assistance in identifying new requirements for IMSA/MEDLOG Bn/USAMMCE stockage or need assistance in establishing a local resupply mechanism.

(d) The pipeline for heavily demanded materiel has been interrupted.

(e) A new, high priority mission is demanding expedited support.

c. Inventory accuracy rate

(1) The inventory accuracy rate provides information regarding the accuracy of on-hand balances recorded on accountable records.

(a) Formula:

$$\frac{\text{Total Number of Lines Requiring Adjustment}}{\text{Total Number of Lines Inventoried}} \times 100 = \text{Percentage}$$

Then,

Percentage - 100% = Inventory Accuracy Rate

(b) Example: If 100 lines required adjustment at the conclusion of the inventory and 1,000 lines were counted,

$$\frac{100}{1{,}000} \times 100 = 10\%$$

(c) Then, 100% - 10% = 90%
The inventory accuracy rate is 90 percent.

(2) Performance measures are as follows:

(a) Management objective: 95 percent.

(b) Management level: 90 percent or above.

(3) Values less than 90 percent indicate a problem as to the reliability of on-hand balances. Problems affecting accuracy may be failure to post receipts in a timely manner or issuing items by the wrong unit of issue.

d. Percent of excess to total inventory.

(1) Excess inventory is that materiel measures both the stocked and non-stocked inventory that is not supported by demands.

(a) Formula:

$$\frac{\text{Dollar Value of Excess Inventory}}{\text{Dollar Value of On - Hand Inventory}} \times 100 = \text{Percent of Excess to Total Inventory}$$

(b) Example: The account has $25,000 of excess (stocked and non-stocked combined) as shown in the Stock Status Report (or DMLSS Excess Report). Total dollar value of on-hand inventory is $1,000,000. The percent of excess to total inventory would be:

$$\frac{\$25{,}000}{\$1{,}000{,}000} = 0.025 \times 100 = 2.5\%$$

(2) Performance measures are as follows:
(a) Management objective: 10 percent or less.
(b) Management level: less than 15 percent.

(3) A rate greater than 15 percent indicates that the account is not taking timely action to remove non-demand supported items from the inventory.

e. Maximum percent of IMSA/MEDLOG Bn pharmaceutical stockage levels CONUS activities only).

(1) This measures the percent of pharmaceutical stocks to the value of annual pharmaceutical orders. The intent is to maximize utilization of government contracted commercial distributors (PV/ECAT). Utilizing these contracts results in inventory reduction through engaging "Just in Time" supply support.

(a) Formula:

$$\frac{\text{Dollar Value of Pharmaceutical Stockage Level}}{\text{Annual Total Dollar Value of Pharmaceuticals Ordered}} \times 100 \text{ Max \% of Pharmaceutical Stockage Levels}$$

(b) Example: The IMSA/MEDLOG Bn has a stockage level for pharmaceuticals valued at $50,000. During the year, the pharmacy service ordered $5,000,000 of pharmaceuticals directly from a government contracted commercial distributor. The percent of IMSA/MEDLOG Bn pharmaceutical stockage level would be:

$$\frac{\$50{,}000}{\$5{,}000{,}000} = 0.01 \times 100 = 1\%$$

(2) Performance measures are as follows:
(a) Management objective: Less than 4 percent
(b) Management level: None

(3) A rate of 4 percent or greater may indicate that the IMSA/MEDLOG Bn is investing too many dollars in pharmaceutical inventory. In this case the IMSA/MEDLOG Bn is not taking advantage of PV/ECAT contracts as a means of reducing inventory.

3-66. MEASURING PROCESSING TIME

a. Request processing time:

(1) For stocked lines, it is the number of days from the date a customer request is received at the IMSA/USAMMCE/MEDLOG Bn to the date the materiel is delivered to the customer or the customer is notified that the materiel is ready for pickup.

(2) For nonstocked lines, it is the number of days from the date a customer request is received at the IMSA/USAMMCE/MEDLOG Bn to the date the request is passed to the supply source or to the supporting contracting activity.

(a) To compute the request processing time at the IMSA/USAMMCE/MEDLOG Bn, survey past customer requests. The date received is not counted; however, the date passed to the supply source or supporting contracting activity is counted, as is the date of delivery or date of notification to the customer. The computation is:

the Processing Time = Date Passed minus (–) the Date Received plus (+) 1

As such, when the requisition is passed on the same day it was received the Processing time is one (1) day.

(b) This measure indicates the efficiency of the IMSA/USAMMCE/MEDLOG Bn in processing requests for both stocked and nonstocked lines. Longer processing times may indicate:

- System deficiencies
- Inadequate staffing
- Training shortfalls
- A combination of these factors

(3) Performance measures are as follows:

(a) Management objective: One (1) day

(b) Management level: One to two (1 to 2) days.

b. Receipt processing time:

(1) This measure represents the lapsed time from the receipt of materiel at the IMSA until the receipt is posted to accountable records.

(2) Use the receipt documentation and accounting records to obtain needed information. The date received is not counted; however, the date posted is counted. The computation is similar to above, Receipt Processing time = Date Posted – Date Received + 1.

(3) Performance measures are as follows:

(a) Management objective: 1 day

(b) Management level: 1 to 2 days

(4) Longer processing times may indicate:

(a) Inadequate receiving or posting procedures

(b) Training needs

(c) Staffing level problems

3-67. MEASURES OF STORAGE MANAGEMENT

a. Materiel release denial rate (warehouse denials).

(1) This is the percentage of Materiel Release Orders (MRO)/pick list denied by storage. It indicates the number of MROs/pick list lines generated where stock is not on-hand in the warehouse, though records indicate that on-hand balances exist.

(a) Formula:

$$\frac{\text{Number of MRO Denials}}{\text{Total MROs}} \times 100 = \text{Materiel Release Denial Rate}$$

(b) Example: If there are 28 MRO/pick list denials out of 3,253 total MROs/pick list lines, then:

$$\frac{28}{3{,}253} \times 100 = 0.9\%$$

(2) Performance measures are as follows:

(a) Management objective: 1 percent

(b) Management level: 0-2 percent

(3) This measure can indicate a variety of potential problems, such as:

(a) Erroneous inventories

(b) Locator inaccuracies

(c) Stocks released to customers without the transaction being posted to accountable records

(d) Inaccurate selection of materiel for shipment or delivery

(e) Erroneous quantities verified on receipt documents

(f) Erroneous posting of receipt documents or misappropriation.

b. Location accuracy (see *AR 710-2*).

(1) This measure is a comparison of locator records with actual physical location of assets expressed as a percentage of accuracy. It is produced from a random sample of storage locations from either the locator records or from the physical location.

(2) There are two types of location survey errors:

(a) Location records showing a recorded location without corresponding stock at that warehouse location, provided that a permanent location is not being reserved for the item.

(b) Physical assets in warehouse locations without a supporting location record.

(3) Formula

$$\frac{\text{Total Correct Inventory Locations}}{\text{Total Inventory Locations Surveyed}} \times 100 = \text{Location Accuracy}$$

(4) Example: If out of 150 locations surveyed, 146 were correct, then:

$$\frac{146}{150} \times 100 = 97\%$$

(5) Performance measures are as follows:

(a) Management objective: 98 percent

(b) Management level: Greater than 95 percent

(6) Location accuracy shows the effectiveness of the storage activity at placing materiel in its designated location and posting appropriate data to locator records, to include deleting invalid location assignments resulting from re-warehousing (reorganizing and restocking the current warehouse) and stock depletion.

3-68. MEDICAL MATERIEL STORAGE

a. Storage conditions: Specialized procedures and equipment are required to prevent the deterioration of medical materiel in storage. Medical materiel is frequently sensitive to sunlight, heat, freezing temperatures and moisture/humidity. Therefore:

(1) Proper temperature monitoring is paramount to cold chain management. The majority of commonly stored vaccines, blood products and other temperature sensitive items are collectively referred to as Temperature Sensitive Medical Products (TSMP) require controlled storage temperatures of 2°C to 8°C (36°F to 46°F) while others must remain frozen at -20˚C to -10°C (-4ºF to 14°F). Additionally, some TSMPs are sensitive to sunlight, moisture, and require special equipment to protect them from deterioration during transport, storage and distribution. Maintain the manufacturer specified environmental conditions to ensure potency, purity, and chemical composition of the TSMP.

(2) Each MTF will develop and maintain Policy for monitoring refrigerators/freezers storing TSMP. Within the Policy, the Commander will, designate a single MTF entity with overall responsibility for monitoring TSMP, and identify an acceptable $-value risk level below which refrigerators/freezers are not required to have a centrally monitored electronic alarm system. Vaccines and Mission Essential TSMP are excluded from this commander's prerogative and require a centrally monitored electronic alarm system. The information below is provided as a guideline.

(a) A temperature alarm system will be installed on refrigerators/freezers storing TSMP. The alarms will be monitored electronically and physically on a 24 hours, seven days per week (24/7) basis. The optimal choice is a system that will both monitor and record temperatures for easy retrieval on a frequent basis and possess the capability to alert individuals (telephonically, pager etc.) tasked to take appropriate action to safeguard the TMSP should storage conditions become compromised.

(b) The entire alarm system from the refrigerator/freezer unit to the remote monitoring station will be tested monthly at a minimum. Areas continually occupied on a 24/7

basis such a Blood Banks or Laboratories may test quarterly. The organization will retain documentation of the test for a minimum of 6 months and a copy will be furnished to the entity with overall responsibility for monitoring TSMP. The alarm system on all units will be installed so as to sound at the Administrative Office of the Day (AOD), installation Fire Station, Provost Marshal Office, or other location that is monitored 24/7. Storage areas with restricted access will have a device installed (light indicator/audible alarm) indicating when the storage unit temperature is out of range and can be checked without physically entering the restricted area.

(c) Local policy will include: (1) the requirement to physically check and document such check of all refrigerator/freezer units storing TSMP 4 times each day (every six hours) and (2) the location of all applicable refrigerator/freezers.

(d) Activities will develop a policy identifying an alternate storage facility (Clinic, Laboratory, Pharmacy, external storage facility, etc.) and specifying building/room numbers that have emergency/back-up power (generator) and storage capacity where TSMP can be temporarily relocated and monitored if necessary. If moved to an interim storage location, documented the chain of custody and accountability for the TSMP items. Additionally, identify proper handling procedures and the means of transport to the secure storage location.

(e) The policy as a minimum must include emergency contact/notification information for the following:

1) Logistics, Pharmacy, Laboratory, Provost Marshal, and Medical Maintenance personnel
2) Refrigeration repair technician
3) Temperature alarm repair technician
4) Alternate storage areas
5) Dry ice vendors
6) Emergency repair companies
7) Vaccine manufacturers, e.g.,
   Merck Sharpe & Dohme: 800-672-6372;
   Aventis Pasteur: 800-VACCINE (800-822-2463);
   GlaxoSmith Kline: 888-825-5249;
   Wyeth Lederle Labs: 800-666-7248.

(These companies may change over time and the list must be kept current).

(f) The Policy must include methodology the MTF will use to determine if the TSMP is still viable and identify who is the approving authority (example: Pharmacy/USAMMA/ Manufacturer?).

(g) Activities maintaining TSMP outside the MTF storage areas such as a Soldier Readiness Processing (SRP) site or clinics should minimize on-hand stock to reduce potential losses. These sites will post temperature logs in their refrigerator/freezer unit that must be filled in at least twice daily. If this is not feasible, alternative monitoring procedures are required and must be included in the SOP.

(h) The activity must document <u>any</u> loss of TSMP due to out-of-range temperatures with the precise date and time sequence. A Commander's Critical Information Requirement (CCIR) must be prepared documenting the loss and forwarded to the Commander and his designated appointee immediately.

b. The IMSA/MEDLOG Bn/USAMMCE and other medical supply operations will comply with all special instructions on the item, shipping label, manufacturer's literature, UDR or in the FSC.

c. In addition to environmental (temperature/humidity) storage requirements, specific storage requirements must be met for the following items:

(1) X-ray film will be stored per manufacturer's recommended storage methods, usually on edge in a vertical position (Film may fog if stored horizontally).

(2) Remove all Dry-cell batteries from instruments prior to storage.

(3) Rubber goods will be stored in rolls or laid flat. Talc will be used to separate surfaces.

3-69. STORAGE METHODS FOR IMSAS, MEDLOG BNS, USAMMCE, AND OTHER MEDICAL SUPPLY OPERATIONS

a. Store medical materiel in unit of issue and/or unit of measure. Establish stock control records for both unit of issue and unit of measure items. Determine the unit of measure price by dividing the unit price by the number of units of measure in the unit of issue.

$$\frac{\text{Unit Price}}{\text{\# of Units of Measure in the Unit of Issue}} = \text{Unit of Measure Price}$$

b. Store controlled items that require special storage and handling procedures to protect against theft per *AR 190-51*.

c. Store hazardous materiel, including acids, flammables, corrosives, gasses, and poisons per:

(1) Technical manual (*TM) 743-200-1*.

(2) *TM 38-410/Defense Logistics Agency Manual (DLAM) 4145.11/Navy Supply Publication 573/AFR 69-9/MCO 4450.12*.

(3) *AR 200-1*.

(4) Applicable Federal, state and local laws.

d. When storing hazardous materiel, at a minimum, the activities must:

(1) Consider the:

(a) Compatibility of chemicals

(b) Ventilation

(c) Fire protection

(d) Spill prevention and response

(e) Containment

(f) Protection from the weather

(2) Locate an inventory list and all applicable MSDS near the storage area within the HCA.

e. Provide heat, refrigeration, and humidity control where necessary to protect stock (see *TM 743-200-1*). Physically separate suspended materiel from other stocks and mark with the authority for suspension.

f. Establish stock locator systems, automated or manual, at each storage site to control the use of storage space. Survey all storage locations at least annually, and reconcile survey results with the locator file.

g. Medical supply operations must establish stock locator systems per:

(1) MACOM or Command Surgeon guidance

(2) *AR 710-2*

(3) *DoD 4145.19-R-1*

3-70. MEDICAL INSTRUMENT RECYCLING PROGRAM

a. Program definition

(1) The Medical Instrument Recycling Program (MIREP) provides for the repair, refinishing, and reconditioning of economically repairable instruments. It applies to medical and dental instruments and involves returning the instruments to a serviceable condition.

(2) Recycling includes:

(a) Replacing missing parts for example, screws and carbide inserts.

(b) Adjusting for proper tension.

(c) Redefining ratchets.

(d) Sharpening cutting edges.
(e) Cleaning, re-polishing, and re-plating surfaces.
(f) Realigning tips and edges.

b. Implementation

The MTF commander will establish a MIREP if economically feasible based upon a cost benefit study. Costs inherent to administering the MIREP contract must be judiciously considered. A copy of the cost benefit study will be retained on file for review by the USAMEDCOM command logistics review program team. If determined not economically feasible, an update review of the cost benefit study will be conducted annually.

c. Recycling guidance

(1) Instruments that are damaged or unsuitable for use will be turned in to a designated collection point by the functional area within the MTF. String or other appropriate binding may be used to group like items for ease of management and turn in. Groups should be tagged. The tags should indicate the NSN/MCN (Management Control Number), nomenclature, total number in group, and generating functional area.

(2) The designated collection point program manager will determine the procedures for turn-ins and account for all receipts, repairs, and disposals. If a PR is initiated for each turn-in to the contractor, a suspense copy should be retained on file.

(3) Recycling costs will be borne by the functional area.

(4) The MIREP assets will remain functional area-owned from the time of turn in until the item is subsequently reissued.

(5) All instruments must meet the following recycling criteria:

- The instrument should be unserviceable or otherwise unsuitable for use.
- A replacement item is required to accomplish the mission.
- The replacement unit cost exceeds $8.

(6) The estimated recycling cost is less than 60 percent of estimated replacement cost.

(7) The Accounting Requirements Code (ARC) is D (that is, a durable item) in the AMDF or FEDLOG or a similar nonstandard item.

d. The MTF commanders may exempt any specific instrument from MIREP for a valid reason. A record of exempt items and the reason for exemption will be maintained on file.

e. Medical instrument recycling equipment program contracts
Recycling services will be obtained through local purchase procedures. Contracts will provide for:
(1) An itemized receipt for instruments turned over to a contractor for recycling.
(2) An itemized statement of recycling cost.

3-71. CUSTOMER SUPPORT

The IMSA will have a “Customer Support Pamphlet” for the customers that details how customers receive support from the IMSA. Support for external customers can either be an “Appendix A” to the Pamphlet or a stand alone document. As a minimum, that Pamphlet will address:

a. Logistics' Organizational structure with POCs and phone numbers.

b. Detailed specific procedures for all functions of Logistics (excess turn in, requisitioning, maintenance, obtaining status, etc.).

c. Sample documents that customers need to complete prior to visiting Logistics.

3-72. ACCEPTANCE OF GIFTS OF MEDICAL MATERIEL OR EQUIPMENT

a. The Surgeon General may accept gifts to the US Medical Command organizations in accordance with *AR 1-100, Gifts and Donations*. Additionally, the Surgeon General and Commanders of Regional Medical Commands may accept gifts for distribution to individuals within their commands in accordance with *AR 1-101, Gifts for Distribution to Individuals*. Further, a recent amendment to *The Joint Ethics Regulation (JER), DoD 5500.7-R* allows Soldiers who have incurred illnesses or injuries as a result of armed combat or other covered activities, to accept more gifts than previously allowed

b. Gifts to the Army. *Under AR 1-100, Gifts and Donations* the Secretary of the Army accepts conditional and unconditional gifts to Army schools, hospitals, libraries, etc. The Secretary of the Army has delegated authority to The Surgeon General to accept conditional and unconditional gifts of a value of $20,000 or less. The Surgeon General must forward to the Secretary of the Army any offer of a gift of a value greater than $20,000.

(1) Treat unconditional gifts to the unit valued under $1000 as gifts to the unit welfare fund in accordance with *AR 1-100,* paragraph 6b.

(2) Forward all other offers of gifts to US Army Medical Command organizations thru the Staff Advocate to The Surgeon General. Documentation accompanying the offer should identify the donor, describe the gift and estimate the value of the gift. Additionally, the commander or head of the organization should determine whether the gift is appropriate for the activity, whether there are any advantages to accepting the gift, and whether the organization desires the gift. Acceptance of the gift cannot result in any special privileges, concessions, or preferential treatment to the donor. Finally, acceptance of the gift cannot adversely affect the public's confidence in the integrity of the Army.

3-73. SUBMITTING MEDICAL/DENTAL PRODUCT QUALITY DEFICIENCY REPORTS (M/DPQDR) {FORMERLY MEDICAL MATERIEL COMPLAINTS (SF 380)}

SB 8-75-S3, chapter 2, has specific instructions for submitting all medical materiel complaints on a M/DPQDR, regardless of procurement source, to report materiel or equipment that has been determined to be harmful and/or defective that may result in injury or death.

CHAPTER 4. QUALITY CONTROL INFORMATION

This Chapter provides sequentially the procedures to be used by all Activities that store medical materiel.

4-1. QUALITY CONTROL

Medical logistics activities (IMSA/MSA/MEDLOG Bn/USAMMCE/Army Pre-Positioned Stock (APS)) are the focal point for all Quality Control Information, which includes:

a. Dissemination and collection Medical Material Quality Control (MMQC) information.
b. Establish and operate medical materiel surveillance programs, including registering and maintaining materiel in the DoD/FDA SLEP Program.
c. Initiate Action on all Quality Control (QC) information by ensuring that all sequentially numbered USAMMA Quad-Service DoD-MMQC; vendor generated messages; *SB 8-75 series* and recall notices from the supporting commercial distributors' PV are received, registered, validated, observed and disseminated to all customers.
d. Act on all sequentially numbered DoD/FDA SLEP Messages.
e. Provide QC information to medical receiving, storage, shipping, and maintenance elements and to supported activities that consume medical materiel.
f. Provide QC information (such as reports of materiel defects) to the wholesale system based on surveillance findings and reports from customers.
g. Prepare reports or take action as required by regulation, *SB-8-75-S7*, *SB-8-75-S10* (ARNG only) and this SB.
h. Ensure that materiel is stored in such a manner as to prevent deterioration and in accordance with manufacturer's guidance.
i. Act as a source of QC information by conducting a constant surveillance program of medical materiel in storage or use.
j. Dispose of unserviceable materiel through the use of national, regional, or local disposal contracts.
k. Provide logistics assistance to supported units for QC matter.

4-2. SOURCES OF QUALITY CONTROL INFORMATION

a. The Quality Control Information is disseminated in the following ways:
   (1) Department of Defense MMQC (DoD-MMQC) messages
   (2) Army Medical Materiel Information (MMI) messages
   (3) DoD/FDA Shelf Life Extension Program Messages (SLEP)

b. Procedures**:** Supply accounts at the IMSA/MSA/MEDLOG Bn/USAMMCE/APS level will maintain a record, either automated or manual, of these messages in numerical sequence. As a minimum, the data will reflect the date received, message number, NSN (or other identifying number), nomenclature, action required, and remarks. If a message is missing, initiate tracer action through message-routing channels or obtain a copy from either:

   (1) World Wide Web Address: **http://www.usamma.army.mil**

   (2) Commander, USAMMA
   ATTN: MRMC-MMO-SO
   1423 Sultan Dr., Suite 100
   Fort Detrick MD 21702-5001

   (3) The DoD/FDA SLEP System: **https://slep.dmsbfda.army.mil**

(4) Activities with an automated QC module in their inventory management system, i.e., TAMMIS/DMLSS, are not required to maintain a manual register, except for the MMQC messages and the DoD/FDA SLEP messages, which will be retained for at least the current- and the prior- calendar year per *AR 25-400-2.*

c. Transmission:

(1) The DoD-MMQC messages are published on the USAMMA website **(http://www.usamma.army.mil)**. Units and activities of the Active Army, USAR, and ARNG, as well as the other services are required to register on the USAMMA website to receive Department of Defense Medical Materiel Quality Control (DoD-MMQC) messages via email. These messages are also disseminated via FTP to USAMMCE (Germany) and 16th MEDLOG (Korea), and are also provided to the JMAR and DMLSS for dissemination.

(2) The USAMMA MMI messages are also published on the USAMMA website **(http://www.usamma.army.mil)**. Only registered US Army Activities, (Active Army, USAR, and ARNG) will receive the MMI messages via email as well.

d. The DoD SLEP Messages are the responsibility of the DMSB. Their website is: **https://slep.dmsbfda.army.mil**

(1) Effective 13 June 2005 the DMSB established the DoD/FDA SLEP Web Based System. This system is a one-stop shopping for SLEP management and allows each activity to:

Enter their own inventory
View results of FDA testing
View SLEP messages
Be tasked to provide samples to the FDA for testing
Receipt for Labels for extended materiel

(2) Access is limited by password and user permissions. This includes access to the SLEP messages. All testing and extension data provided to the SLEP by the Food and Drug Administration is considered **For Official Use Only** and cannot be shared with anyone outside the user's organization. Sharing this information with local, civilian counterparts is a violation of the terms agreed to by the FDA but also a violation of the Memorandum of Agreement each participant organization signs prior to entering the SLEP program. Non-SLEP organizations that use SLEP information are in violation of Federal law (Code of Federal Regulation 21) that governs "misbranded" pharmaceuticals.

(3) Activities may register for access to the SLEP system. To access the SLEP web application:

- Open your Internet Explorer
- Click on File
- Click on Open
- Type in the following URL https://slep.dmsbfda.army.mil
- Click Okay
- Save this page as one of your favorites

- You should now be at the SLEP Main Page
- Click on <USER REGISTRATION> on the top Left on the page
  - Read the General Counsel Directive
  - Click Continue
- Scroll down the page and make sure that you have a <SUBMIT APPLICATION> button at the bottom of the page. If you do not see it, close your Internet Browser and begin again, your browser did not completely load
- If the <SUBMIT APPLICATION> button is at the bottom of the form, complete the form, ensure you indicate why you need access to the SLEP System (limited to 4 lines). Make sure you use your Activity's Mailing Address. This is where your labels will be sent.
- Once granted access to the system, go to <INVENTORY>, download and print the <INVENTORY HELP>. This will walk you through the program along with the Frequently Asked Questions (FAQs).

Your Password and User ID will be sent to you in 1-2 working days after your Security Officer has responded back to the email requesting verification that you have a positive National Agency Check (NAC).

SEE THE SLEP FAQ ON THE LEFT SIDE OF THE MAIN MENU BEFORE SENDING EMAIL QUESTIONS TO: DMSBDOD-FDASLEP@AMEDD.ARMY.MIL

(4) Activities must be registered to receive SLEP messages. Only SLEP Messages for FY04 and before are available on the USAMMA Web site. All SLEP Messages from 2005 forward are on the DoD/FDA SLEP Web Site.

e. The IMSA/MSA/MEDLOG Bn/USAMMCE/APS are responsible for making distribution of messages to supported customers; except the DoD/FDA SLEP Messages, which are for internal use only.

f. Army National Guard actions: Upon receipt, Chief, National Guard Bureau (NGB) will distribute copies of all MMQC messages to DMSO and ARNG training sites operating troop medical clinics. Additionally, the Chief, NGB, will immediately distribute all MMQC messages concerning Type I medical materiel complaints and the FDA Class I recalls to the State Safety Office and all medical elements in the State, including separate medical detachments and medical sections of maneuver battalions. ARNG units who store stockpiles of medical materiel, e.g. the Weapons of Mass Destruction Civil Support Teams (WMD-CST) will register and maintain their inventory in the DoD/FDA SLEP System as directed by the National Guard Bureau and SB-8-75-S10.

g. The USAR action: The MEDLOG Bns and USARC medical units designated as a SSA within a command or area of operations are responsible for the distribution of all applicable DoD-MMQC messages to supported customers, minus the DoD/FDA SLEP Messages; they are for internal use only. USAR medical units, e.g., MEDLOG Bns, ASMB and hospitals will register for the DoD/FDA SLEP program upon mobilization.

h. On-line query search: The USAMMA has an on-line query capability for all QC messages, SLEP messages before FY05, and information bulletins. Search by Message MMQC/MMI Number, NSN, National Drug Code (NDC), Subject, or Lot Number by accessing the USAMMA homepage at http://www.usamma.army.mil

i. The *SB 8-75 series:* The SBs are distributed through normal Army distribution channels and provide other essential medical logistical information.

j. The *AR 702-18, DLAR 4155.37,* and *AFR 67-43:* These publications contain storage QC procedures and serviceability standards applicable at all levels of materiel management. Questions related to information contained in the publications may be directed to:

Commander, USAMMA
ATTN: MCMR-MMO-PM
1423 Sultan Dr., Suite 100
Fort Detrick MD 21702-5001

The MEDSILS, FLIS, AMDF, FEDLOG, and, UDR: The MEDSILS, AMDF, or FEDLOG, UDR, and FLIS are the official sources of supply management data, i.e., Shelf Life Codes (SLCs), and AAC. They have precedence over conflicting data published in other Army publications as well as *AR 702-18, DLAR 4155.37,* and *AFR 67-43,* unless otherwise stated in DoD-MMQC messages. Issues with SLCs may be sent to DSCP through https://dmmonline.dscp.dla.mil, NSN Action Feedback Form or to the DoD/FDA SLEP Program, DMSBDOD-FDASLEP@AMEDD.ARMY.MIL .

4-3. STORAGE PROCEDURES AND SHELF LIFE OF MEDICAL MATERIEL

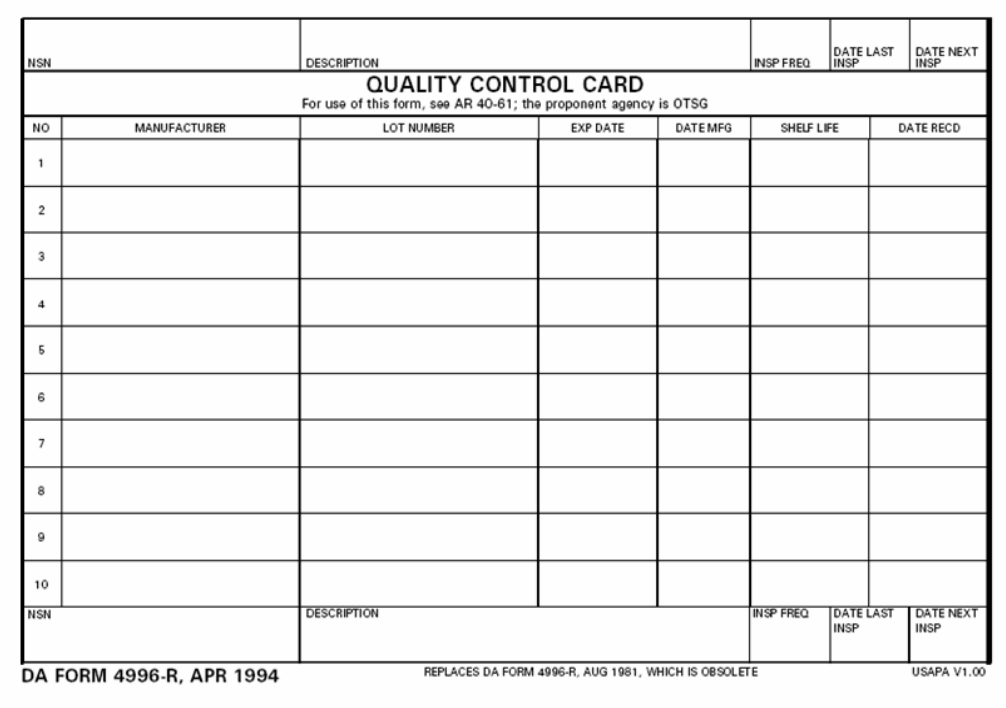
a. All activities that store medical materiel are responsible for the:
(1) Care, preservation, and surveillance of all medical materiel under their control.
(2) Establishment of storage policies for the materiel they store.

b. Store medical materiel in unit of issue and/or unit of measure. Establish stock control records for both unit of issue and unit of measure items. Determine the unit of measure price by dividing the unit price by the number of units of measure in the unit of issue.

$$\frac{\text{Unit Price}}{\text{\# of Units of Measure In the Unit of Issue}} = \text{Unit of Measure Price}$$

c. Storage conditions. Specialized procedures and equipment are required to prevent the deterioration of medical materiel in storage. Medical materiel is frequently sensitive to sunlight, temperature extremes, and moisture. Therefore;
(1) Controlled items requiring special storage and handling procedures to protect against theft, will be stored per *AR 190-51, AR 40-2* and chapter 3 of this *SB*.
(2) Temperature Sensitive Medical Products (TSMP) will be stored and handled as outlined in chapter 3 of this SB.
(3) Hazardous materiel, including acids, flammables, corrosives, gasses, and poisons will be stored per:
(a) *TM 743-200-1*
(b) *TM 38-410/DLAM 4145.11/Navy Supply Publication (NAVSUP PUB) 573/AFR 69-9/MCO 4450.12*
(c) *AR 200-1*
(d) Applicable Federal, state and local laws
(4) When placing medical materiel in storage, at a minimum, consider the following:
(a) Temperature
(b) Compatibility of chemicals.
(c) Ventilation.
(d) Fire protection.
(e) Spill prevention and response.
(f) Containment.
(g) Protection from the weather.
(5) Post an inventory list and all applicable MSDSs near the storage area within the activity.
(6) Suspended materiel will be physically separated from other stock and marked with the authority for suspension, e.g., DoD/FDA SLEP Message # xx, MMQC Message yy

d. Retention of QC records: The IMSA/MSA/MEDLOG Bns/USAMMCE will maintain QC records for all on hand expiration-dated materiel. These records will be maintained in the DMLSS/TAMMIS QC module. Activities without the DMLSS/TAMMIS QC module will use the DoD/FDA SLEP System for all QC records for stocked materiel and the DA Form 4996-R (Quality Control Card) for all other non-FSC 6505 materiel. Other medical supply operations (those with out automated QC systems) will maintain QC records in accordance with command or command surgeon guidance. As a minimum, QC records will reflect the manufacturer, lot number, and current expiration date. Use 8-by 5-inch card stock to reproduce the DA Form 4996-R (See Fig 4-1 on the next page). Table 4-1 provides the preparation steps for DA Form 4996-R. Use QC records to:
(1) Ensure rotation of stocks.
(2) Prepare reports of items that cannot be used prior to expiration for extension, disposal, or destruction.
(3) Budget for replacement of expired stocks.



NSN	DESCRIPTION			INSP FREQ	DATE LAST INSP	DATE NEXT INSP
QUALITY CONTROL CARD For use of this form, see AR 40-61; the proponent agency is OTSG						
NO	MANUFACTURER	LOT NUMBER	EXP DATE	DATE MFG	SHELF LIFE	DATE RECD
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
NSN		DESCRIPTION			INSP FREQ	DATE LAST INSP / DATE NEXT INSP

DA FORM 4996-R, APR 1994 — REPLACES DA FORM 4996-R, AUG 1981, WHICH IS OBSOLETE — USAPA V1.00

Figure 4-1. Sample of DA Form 4996-R

e. Marking potency extensions: Medical items whose potency expiration date is being extended will be re-marked with the new expiration date. The DoD/FDA SLEP will provide labels for each item extended in the SLEP program. Before issue, the label with the new expiration date must be attached covering the current expiration date. The large labels are to be used on the carton/box/pallet, the smaller labels for the individual item. The quantities and lots of labels provided are based on the on-hand inventory reported in the SLEP system. You may not line out expiration dates. Additional direction on placement and use of the labels will be on the back of each label or as directed by USAMMA.

TABLE 4-1. STEPS TO PREPARING DA FORM 4996-R

Step	Description
1	NSN: NSN/MCN/universal product number/NDC (pen entry)
2	Description: Name of item (pen entry)
3	Inspection frequency: How often does this item need to be inspected? [See *AR 702-18 / DLAR 4155.3 7 / AFR 67-43, UDR*, or *Defense Logistics Information System (DLIS)*]
4	Date last inspected: (pencil entry)
5	Date next inspection: (pencil entry)
6	Manufacturer: Name of manufacturer. There may be more than one.
7	Lot number: Lot number from package.
8	Expiration date: Expiration date on package, if applicable.
9	Date manufactured: Date manufactured on package, if applicable.
10	Shelf life: Type I (excluding pharmaceuticals/drugs), Type II, and Estimated Storage Life (ESL) from FEDLOG or UDR
11	Date received: (pencil entry)

4-4. DETERMINING SHELF LIFE FOR MEDICAL MATERIEL

a. The Shelf Life starts when an item is manufactured. The *21 CFR* requires all Pharmaceutical items to have an expiration date (potency and dated) (P&D) affixed. The US Pharmacopeia (USP) founded in 1820, is a non-governmental, nonprofit organization whose mission is to promote public health and is recognized by Federal law as the official body that sets standards for prescription drugs. The USP defines the expiration date as "the time during which the article may be expected to meet the requirements of the pharmacopeia monograph provided it is kept under the prescribed conditions." The expiration date, which limits the time during which the article may be dispensed or used, is based on scientifically sound stability studies and is usually expressed in terms of the month and year, as stated on the manufacturer's container. The product may be used until the last day of the stated month and year, unless it has been extended by the FDA through empirical testing at its labs through the DoD/FDA SLEP program. Medical materiel storage periods are categorized as follows:

(1) Type I shelf life items: Type I items are supply items having a definite storage period terminated by an expiration date that was established by empirical and technical test data. Routinely, these supply items are considered non-extendable except when large quantities are being stored for contingency purposes. In these cases, the supply item may qualify (based on technical and economic considerations) as a candidate for the DoD/FDA SLEP. This program requires testing by the FDA. These items are identified by "01" in the fourth and fifth positions of the MCSC and by an **alpha** character in the SLC.

(2) Type II shelf life items: Type II items are supply items having a definite storage period terminated by an expiration date that may be extended after a prescribed inspection or restorative action. These are identified by "02" in the fourth and fifth positions of the MCSC and by a **numeric** entry in the SLC.

(3) Shelf life condition codes: Shelf life medical materiel is condition coded per *AR 702-1 8 / DLAR 4155.3 7 / AFR 67-43* as follows:

(a) Condition code A - 6 months remain on the shelf life.
(b) Condition code B - 3 to 6 months remain on the shelf life.
(c) Condition code C - less than 3 months remain on the shelf life.

(4) Reclassified materiel: Medical materiel bearing expiration dates are reclassified from condition code A to B or C based upon the number of months remaining in the unexpired dating period. This is automatically done to the items in the DoD/FDA SLEP system. The CONUS and OCONUS activities may receive condition code A stocks for shelf life materiel issued from DSCP. Condition code B stocks are only issued to CONUS activities, with prior approval OCONUS activities may agree to accept Condition Code B stocks. Activities will use, the “Shipment Discrepancies” guidelines (see chapter 3, paragraph 3-45, of this SB) to report any potency dated materiel, which OCONUS activities receive with a shelf life condition coded B or C or CONUS activities receive with a shelf life condition coded C.

b. The FDA, under the DoD/FDA SLEP is the approving authority for medical extensions on Type I shelf life items.

c. The Shelf Life of a medical item is only for the period of time it is in storage. Once removed from storage, its Service life begins. The Service life for a medical item is the period of time it may be used after it is removed from storage and or issued. It is determined by:

(1) How was it stored?
(2) Its current expiration date
(3) The number of hours, days, months it may be used after it is mixed or removed from refrigeration or the freezer, e.g. Pyridostigmine Bromide Tables may only be out of the refrigerator for a total of 90 days to be eligible for issue to an individual.
(4) A maximum of one (1) year from the day issued, per the *US Pharmacopeia <1136> Guidelines*.

4-5. MANAGEMENT OF SHELF LIFE ITEMS

a. Medical logistics activities managing Army Pre-positioned Stocks, MCDM, Unit Deployment Packages (UDP), Installation CBRN, and any other stockpile of Army medical materiel will:

(1) Register for and participate in the DoD/FDA SLEP Program.

(2) Issue the earliest dated materiel first.

(3) Enter on-hand, stockpiled inventory in the DMLSS/TAMMIS QC module or in the SLEP system as soon as the items are received and update the inventory on a quarterly basis.

(4) Store all materiel in a controlled environment under conditions recommended by the manufacturer. Those stocks that were stocked outside of the manufacturer's recommended storage parameters will be reported to USAMMA, ATTN: MCMR-MMO-PM.

(5) Maintain an automated or manual log of the daily temperature and humidity in the storage facility. This information may be reported in the DoD/FDA SLEP System on a monthly basis. Normal temperature for pharmaceutics as defined by the US Pharmacopeia as Controlled Room Temperature is 68-77 degrees Fahrenheit at 60 relative humidity and allows for a variation of between 59-86 degrees Fahrenheit which may be experienced in pharmacies, hospitals and warehouse

(6) Send all samples requested by the FDA for testing with-in 14 days of the request. Instructions on how to ship and where to ship to are on the DoD/FDA SLEP site, SLEP message 2005-57.

(7) Comply with all directions in the DoD/FDA SLEP message, e.g. suspend, destroy, re-label.

(8) Re-Label all products in accordance with the SLEP message. As a minimum, re-label the exterior package/pallet/box. The individual items do not need to be labeled until issued.

(9) See *SB-8-75-S7* (20 July 2007) for additional directions on management of MCDM, APS, UDP and the DoD/FDA SLEP Program.

b. Biologicals. The FDA will not accept shelf life extension requests for FSC 6505 items classified as "biologicals", e.g., vaccines or lab reagents. The USAMMA will provide guidance through MMQC messages on reporting and disposal of biologicals.

4-6. SURVEILLANCE OF MATERIEL

a. All activities stocking medical materiel will establish a surveillance program to:

- provide for the scheduled inspection of medical materiel.
- provide for rotation of mobilization reserve stocks with operating stocks.
- Provide for timely action to preclude undue loss through deterioration or destruction.

The basic publications and systems used for surveillance programs are:

(1) MEDSILS, FLIS, AMDF, FEDLOG and UDR
(2) *AR 702-18/DLAR 4155.37/AFR 60-10*, Appendix M
(3) *DA SB 8-75* series
(4) Military Item Disposition Instructions (MIDI)
(5) Universal Data Repository (UDR)
(6) Defense Logistics Information System (DLIS)
(7) Military Environmental Information Source (MEIS)
(8) DoD-MMQC messages
(9) DoD/FDA SLEP messages

b. *AR 702-18 /DLAR 4155.37 / AFR 60-10, and DLAM 4155.5, Appendix M*, contains procedures and standards for visual inspections of medical materiel. The standards identify the physical properties (discoloration, precipitation, odor change, and so forth) indicating product deterioration rendering the item unsuitable for issue and use. The *Appendix M* is available on the USAMMA web site at http://www.usamma.army.mil

4-7. INSPECTION OF LOCALLY PURCHASED MATERIEL

a. Personnel assigned to the receiving section of the IMSA/MSA/MEDLOG Bn/USAMMCE/APS will inspect all materiel before acceptance. When materiel is delivered direct to the activity/requester, individuals receiving materiel are required to conduct an inspection prior to acceptance. Applicable MMQC, MMI and SLEP messages should be used for this surveillance. Furthermore, IMSA/MSA/MEDLOG Bn/USAMMCE/APS will report any problems discovered relative to usage as medical materiel complaints. This requires a visual inspection of materiel to ensure that the product appears in good condition. For specialized materiel requiring inspection expertise beyond the capabilities of the IMSA/MSA/MEDLOG Bn/USAMMCE/APS, the requester or other appropriate specialist should assist in the inspection. The supporting medical maintenance activity will perform technical inspections of all medical equipment as appropriate. Receiving reports will be processed in a timely manner. Report problems with materiel identified after processing the receiving report to the supporting contracting officer for appropriate resolution. The USAMMA can provide assistance in specialized or technical inspections.

b. The IMSA/MSA/MEDLOG Bn/USAMMCE/APS or credit card holder will respond within the scope of their authority using local credit card procedures to resolve the issues. Contact the issuing contracting office for further resolution as required.

c. The receiving activity/requester must forward a copy of the MSDS when direct delivery occurs to the IMSA/MSA/MEDLOG Bn/USAMMCE/APS and comply with the activity's hazard communication program.

4-8. RECALL OF NONSTANDARD DRUGS AND DEVICES

a. A nonstandard drug is defined as any item that does not have a DMSB-approved NSN. Nonstandard drugs and devices announced by the FDA as being recalled by manufacturers/distributors will be published in DoD-MMQC messages.

b. Activities having quantities of these items on-hand will suspend the materiel from issue and use.

c. The CONUS activities will contact the respective manufacturer or distributor for disposition instructions.

d. The OCONUS activities will comply with DoD-MMQC messages. If further disposition instructions are required, report NSN and quantities suspended to:

Commander, USAMMA
ATTN: MCMR-MMO-SO
1423 Sultan Dr., Suite 100
Fort Detrick MD 21702-5001

Reports must include the following items:

MMQC message reference
Nomenclature
Lot or batch number
Quantity
Requisition number under which the materiel was obtained
Purchase order or contract number
Location of the materiel.

e. The USAMMA will coordinate with DSCP or the manufacturer for disposition instructions and will advise the reporting activities.

f. The OCONUS activities may contact the responsible manufacturer or distributor for items procured directly from an overseas acquisition source other than DSCP.

4-9. DISPOSAL AND DESTRUCTION

The preferred method of destruction is using contracted services for disposal of unserviceable medical materiel. In the event that the item(s) cannot be disposed of using contracted services, then local destruction of unserviceable medical materiel is authorized. Local destruction is restricted to those items approved by the Environmental Science Officer (ESO) of the Preventive Medicine (PMed) Service consultants or ESO from the RMC/MSC.

a. The IMSA/MSA/MEDLOG Bn/USAMMCE/APS will accept items for destruction from any activity not capable of accomplishing destruction actions. This acceptance constitutes informal accountability and storage by the IMSA/MSA/ MEDLOG Bn/USAMMCE pending review by the ESO destruction officer. The IMSA/MSA/MEDLOG Bn/USAMMCE/APS will sign the DA Form 3161 (Request for Issue or Turn-In) from the activity to show acceptance and storage of the items pending environmental review and destruction.

b. The activity submitting medical materiel for destruction will complete a DA Form 3161 clearly marked “FOR DESTRUCTION PURPOSE ONLY” (see Table 4-1). Document numbers for the DA Form 3161 will be assigned by the requesting activity. The IMSA/MSA/MEDLOG Bn/USAMMCE/APS will assign a voucher number to the document (considered a debit/credit voucher and not posted to the accountable records) for internal control and filing.

c. Medical materiel authorized for destruction will be processed as follows:

(1) The fixed facility HCA or deployable unit commander will appoint a disinterested officer (E7/GS 07 or above) to be responsible for all destruction at the IMSA/MSA/MEDLOG Bn/USAMMCE/APS or deployable unit and for controlled substances at the user level.

(2) The ESO/destruction officer will certify as to the accuracy of all facts entered on destruction documents. Units not authorized TAMMIS-MEDSUP/DMLSS may use DA Form 3161 as their destruction document (see Table 4-1). Activities using TAMMIS-MEDSUP/DMLSS will use the system generated destruction document. The statement shown in Figure 4-2, signed by two witnesses, will be placed on the destruction document below the signed certificate of the ESO/destruction officer.

d. The MIDI/MEIS provides guidance for the destruction of materiel. If a method of destruction code is required but not assigned, contact:

Commander, US Army Center for
Health Promotion and Preventive Medicine
ATTN: MCHB-TS-EHM
5158 Blackhawk Rd.
Aberdeen Proving Ground MD 21010-5403

Items included are as follows:

(1) Unidentifiable items or items which, when intended to be disposed of, are hazardous wastes according to criteria developed under the authority of Public Law 94-580 and its implementing Federal and state regulations, such as *Title 40*, Parts 260-270, *(40 CFR 260-270).*

(2) Partially used items that are excess. These items tend to deteriorate faster after the opening of a container. The packing list or attached covering label may not actually describe the contents of the container.

(3) Items cited for destruction by the MMQC or MMI messages

(4) Items cited for destruction by the DoD/FDA SLEP messages and the SB 8-75 series.

e. Destruction and documentation of destruction will comply with the following:

(1) When a contractor disposes of hazardous waste, contracts will contain a statement requiring the contractor to furnish a certificate of destruction with the invoices for payment. Follow-up will be made on the status of destruction when invoices are received without a certificate of destruction.

(2) A witnessing statement on the DA Form 3161 is not required when a contractor accomplishes destruction of hazardous waste.

(3) Local controls will be established to ensure that the contractor is given an itemized listing indicating the product identification number, nomenclature, unit of issue, quantity, and shipping weight of all items to be picked up for destruction. This listing will be filed with the required DA Form 3161.

(4) The completed DA Form 3161 will be used as a voucher for dropping the materiel from accountability. It will cite the reason for destruction, method of destruction (disposal code) (MIDI), and the location of destruction.

(5) When instructed by the USAMMA or DSCP, the medical activity will submit certificates of destruction. Where credits are involved, the local finance and accounting division must also submit MILSTRIP DIC FAE (request for billing adjustment) transaction. This transaction generates interfund credits from the DSCP while the certificate is used by the DSCP to support claims for reimbursement against contractors. (See *AR 725-50*)

(6) The Chief of Preventive Medicine Service (or designated representative(s)) will review destruction documents from HCA customers and certify that the destruction codes assigned to the items are correct. The installation environmental coordinator will review destruction documents from deployable units that have the capability of performing their own destruction actions. The destruction codes will be checked using the publications stated above. The following statement will be cited on all destruction documents and will be signed by the ESO or installation environmental coordinator:

"I certify that the destruction codes assigned to the above items are acceptable, environmentally sound, destruction/disposal methods for this materiel, and comply with Federal, state, and local laws."

(7) Materiel in less-than-unit-of-issue quantity will be informally accounted for pending destruction. Keep a copy of the turn-in document with the materiel until destruction. Upon destruction, file the copy with the destruction certificate.

(8) Note R and Q drugs less-than-unit-of-issue quantities will not be turned in to IMSA/MSA/MEDLOG Bn/USAMMCE/APS. They will be returned to the supporting pharmacy for destruction.

TABLE 4-2. STEPS TO PREPARING DA FORM 3161 AS A DESTRUCTION DOCUMENT

Step	Description
1	**Sheet Number:** Self-explanatory.
2	**Number of Sheets:** Self-explanatory.
3	**Voucher Number:** Self-explanatory.
4	**Send to:** Destruction.
5	**Request from:** Activity/unit desiring destruction.
6	**Item Number:** Self-explanatory.
7	**Stock Number:** Enter NSN, MIIN (Medical Item Identification Number), NDC, UPN, or MCN.
8	**Item Description:** Brief nomenclature, manufacturer, lot number, expiration date/manufacture date, and reason for destruction, e.g., expired, MMQC message, manufacturer's recall, broken, non-returnable excess.
9	**Unit of Issue:** Self-explanatory.

Step	Description
(Continued - Table 4-2)	
10	**Quantity:** Enter quantity to be destroyed.
11	**Code:** Destruction Code from the MIDI, U.S. Army Center for Health Promotion and Preventive Medicine, or activity ES/PMed officer. If the code is obtained from other than the MIDI, state from whom and when.
12	**Supply Action:** The quantity actually destroyed. Entered by Destruction Officer.
13	**Unit Price:** Self-explanatory.
14	**Total Cost:** Self-explanatory.
15	**Sheet Total:** The sum of all lines on the sheet.
16	**Grand Total:** The sum of all sheet totals for the same voucher number.
17	The document will be closed with either "LAST ITEM" or "NOTHING FOLLOWS."
18	The destruction officer's certificate will begin on the next available line or on a continuation sheet. The certificate will be signed and dated. The destruction officer's name and grade of the will typed. The certification statement should state specifically how each line was destroyed following the codes assigned and definitions provided in the SB 8-75 series. **NOTE:** If the items are turned over to a contractor for destruction, the name of the contractor will be shown, the destruction certificate will be changed to reflect this action, and the representative will sign for receiving the items in the presence of the two witnesses.
19	If the materiel is buried in an on-post landfill, the grid coordinates of the site will be shown. If using an off-post landfill, include specific address (street, city, state) and grid coordinates. If the materiel is incinerated, include the on-post building number or specific off-post address.
20	The witnesses' statement (see the sample in figure 4 below), will start on the next available line. The statement will be signed and dated by both witnesses. Be sure typed names and grades are included.
21	The certification of the ESO/destruction officer will begin on the next available line. When an ESO is not assigned, the appointed Destruction Officer will sign the certification. This certification is required for Federal, state, and local environmental standards.
22	Add a statement on the destruction document that credit was sought but not granted if the destruction includes nonstandard drugs or biologicals with a line acquisition value of $100 or more and replacement or credit was not obtained.

Figure 4-2, below, is an **example** of the Destruction Statement Format.

I have witnessed the destruction of the materiel described which was(were) destroyed on the date and in the manner stated.

(Signature) Witness 1) (Typed name, Witness 1))

(Signature) Witness 2) (Typed name, Witness 2))

Figure 4-2. Destruction Statement Format

4-10. QUALITY ASSURANCE FOR MEDICAL GASES

a. Bulk (liquid) gases may be oxygen or ethylene oxide. The Quality Assurance (QA) procedures for bulk (liquid) gases are:

(1) The HCA Commander will designate in writing, those individuals who received training in the use of the gas analyzer as being responsible for monitoring bulk gas deliveries. These individuals will:

(a) Document name of individual responsible for receipt of bulk gas and date and time of delivery.

(b) Document the results of gas analysis before acceptance.

(c) Document amount received.

(d) Document corrective actions if gas fails to meet standards (less than 95 percent by volume for oxygen).

(e) Maintain (or cause certification/documentation) of accuracy of the gas analyzing equipment.

(2) The HCA Commander will ensure that the bulk gas storage container has an outlet that allows for gas analysis. Specific storage procedures for bulk gases are found in *AR 700-68* and NFPA codes.

(3) Records of receipt and gas analysis must be maintained for two years per *AR 25-400-2.*

(4) The HCA Commander will establish a written plan to handle bulk gas emergencies (medical gas alarms or equipment failures). This plan must identify clinical areas requiring alternate gas supply until the central supply is functioning properly.

(5) Equipment using bulk gases must be tested for proper functioning before patient's use. Follow manufacturer guidelines to complete this testing.

(6) The HCA Commander must ensure that all personnel handling bulk gases are properly trained. Training must be documented and documentation retained.

b. Medical gases maintained in cylinders require QA procedures.

(1) Upon receipt, the cylinders containing oxygen must have DD Form 1191 (Warning Tag for Medical Oxygen Equipment) attached (*TB MED 245*). The oxygen purity %, name of individual testing the oxygen purity and date of the test will be written on the DD Form 1191.

(2) Cylinders containing any gas must have the cylinder valve cap in place when so designed.

(3) Cylinders must be inspected upon receipt for proper color-coding, bulges, or damage (*MIL-STD-101*).

(4) Cylinders must be stored per NFPA codes and *AR 700-68*.

(5) Cylinders cannot be refilled and shipped if past retest date(s). Use gas from a cylinder that is past due for retest is permitted. No time limit is imposed.

(6) Safe handling practices of cylinders *(TB MED 245)* must be followed.

(7) Disposal and turn-in procedures are contained in *AR 700-68,* Sections 7 and 8.

4-11. SUBMITTING MEDICAL MATERIEL COMPLAINTS (MEDICAL/DENTAL PRODUCT QUALITY DEFICIENCY REPORT)

A Medical or Dental Product Quality Deficiency Report (M/DPQDR) should be submitted to report materiel or equipment determined to be harmful and/or defective that may result in death, injury, or illness. M/DPQDRs are categorized into two types:

- Category I: Materiel that has been determined by use or testing to be harmful or defective to the extent that its use has or may cause death, injury, or serious illness.
- Category II: Drugs, devices, supplies, or equipment that is suspected of being harmful, defective, deteriorated, or unsatisfactory because of malfunction or design, which are attributable to faulty materiel, workmanship and/or quality inspection, or performance or are otherwise unsuitable for use.

An M/DPQDR is the customer's way of alerting the system that there is a quality deficiency with a medical or dental product. Deficiencies should be submitted on standard and nonstandard items. The submitter will receive a copy of the e-mail sent to DSCP, the Defense Medical Standardization Board (DMSB) and the Services' Medical Logistic Offices at Ft Detrick. Once the form is received, DSCP will assign a Report Control Number (RCN) in the Product Data Reporting and Evaluation Program (PDREP), and respond back to you normally within two days. For more information about the PDREP program go to http://www.nslcptsmh.navsea.navy.mil/pdrep/pdrep.htm

a. All medical materiel complaints, regardless of procurement source, will be submitted on a Complaint Form to DSCP via online at https://dmmonline.dscp.dla.mil/forms/mpqdr_entry_new.asp

b. Complaint Forms completed on nonstandard items procured through DSCP must cite the purchase order number and document number.

c. Report the circumstances of Type I complaints immediately to DSCP, through the quickest means, that is, by telephone or immediate message.

(1) **During normal duty hours** (0700 - 1700 hours Eastern Time), call the:
DSCP ESOC at DSN 444-2111/2112, or commercial 215 737-2112.
A fax may also be sent to:
Commercial 215 737-2081/7109 or DSN 444-2081/7109.

(2) **After duty hours**, these numbers will automatically transfer to the Staff Duty Officer. If the transfer does not occur or the call is not answered, call the following numbers: DSN 444-2341 or commercial 215 737-2341.

d. The HCA submitting Type I complaints will document the call immediately and send written confirmation within 12 hours via facsimile or submit a Complaint Form online. For Type I complaints only, the identity and contact information for the authorizing Medical Officer is required. When a Type II or III complaint is determined appropriate, the medical unit will submit the Complaint Form within 48 hours either by mail to the DSCP address shown below:

Facsimile to DSN 444-3120/Commerical 215-737-3120
Telephonically to DSN 444-2891/Commerical 215-737-2891 or online.

Director, DSCP
ATTN: DSCP-MRCM
700 Robbins Ave
Philadelphia PA 19111-5092

e. Follow-up by mail or electronically with photographs and drawings of equipment with Type III complaints to help describe or substantiate the complaint.

f. Include a specific statement on the storage conditions of the materiel on the Type II complain. An example of the statement would be: “Controlled temperature warehouse or unheated warehouse.”

g. Forward copies of the Complaint Form as directed below:

(1) If not submitted online**,** forward one copy of complaints regardless of procurement source to:

Director, DSCP
ATTN: DSCP-MRCM
700 Robbins Avenue
Philadelphia PA 19111-5092

One copy of complaints on standard and nonstandard materiel purchased locally to the appropriate local contracting activity.

(2) One copy of complaints for GSA catalog materiel to the GSA regional office.

(3) Information copies of all complaints will be sent to the following addressees

(a) Defense Medical Standardization Board
ATTN: Staff Director
1423 Sultan Drive
Fort Detrick MD 21702-5013

(b) Commander, USAMMA
ATTN: MCMR-MMO-SO
1423 Sultan Drive, Suite 100
Fort Detrick MD 21702-5001

h. The preferred method for the submission of a complaint is electronic filing of a Complaint Form. This method provides simultaneous copies going to DSCP, the DMSB, and the USAMMA, through the INTERNET at https://dmmonline.dscp.dla.mil/forms/mpqdr_entry_new.asp . Upon submission of the complaint, DSCP acknowledges receipt of the complaint via email or other method.

i. Medical materiel complaints submitted on a Complaint Form are exempted from information requirements control under *AR 335-15*.

j. The *21 CFR* prescribes reporting certain materiel/equipment conditions to the FDA under the Safe Medical Devices Act (SMDA). Logistics personnel will coordinate and provide a copy of the Complaint Form to the Risk Manager as part of the Risk Management Program. The Risk Manager is required under Joint Commission (JC) guidelines to review the SMDA information on the Complaint Form and assess the potential risk. Additional reports may be required under *AR 385-40*

CHAPTER 5. MEDICAL EQUIPMENT MANAGEMENT

5-1. PROPERTY ACCOUNTABILITY AND MANAGEMENT

a. USAMEDCOM requires activities to maintain formal property book accounting records only for equipment costing $5,000 or more with the exception of equipment that falls into one of the below criteria, these items require formal property book accountability regardless of cost:

(1) Rented, leased, or loaned Property.

(2) Maintenance significant equipment including Test, Measurement and Diagnostic Equipment (TMDE).

(3) Army-managed items with Reportable Item Control Codes of 2, A, B, C, D, E, F, G, H, and J.

(4) Army-managed items with CIIC 1-9, $, N, Q, R, and Y (night-vision goggles) (these items are categorized as sensitive and inventoried quarterly).

(5) Property determined to be highly pilferable to include property potentially convertible to private use, or has a high potential for theft. Regardless of cost, this property is recorded and controlled as accountable property. Included in this category, but not limited to, are the following items:
Photocopy Machines, Video Cameras, Video Cassette Recorders, Televisions, Automatic Data Processing Equipment (Personal Computer Systems, Laptop Computers, External Modems and disk drives, personal data assistants (PDAs), Printers and Plotters), Facsimile Machines, Portable and Cellular Telephones and All Firearms.

(6) Property authorized by TDA.

(7) Property authorized by *CTA 50-900.*

(8) Property authorized by *CTA 50-909.*

(9) Research, development, test and evaluation property authorized by *AR 70-6.*

(10) On-hand commercial items similar to items coded non-expendable in FEDLOG.

(11) Homeland Defense and Special Medical Augmentation Response Team equipment. For purposes of accountability, Homeland Defense equipment is defined as all Hazardous Materiel (HAZMAT) and specialized equipment designed to support MCDM, incidence response. This includes personal protective equipment, decontamination equipment and any other locally procured defensive or response equipment.

b. **Rented, Leased, and Loaned Equipment**: The PBO will establish property accountability for this equipment within three working days after receipt, regardless of the length of the lease, rental, or loan agreement. Identify this equipment with the appropriate ownership code in accordance with system procedures.

(1) The PBO will maintain a leased equipment file for each contract IAW *AR 710-2*. The PBO will establish similar folders for rented and loaned equipment. For medical equipment, include a copy of the maintenance acceptance inspection work order in addition to the documents required by *AR 710-2* and *AR 71-32*.

(2) A lease/purchase analysis is required for each lease/rental over 60 days in accordance with the *Defense Federal Acquisition Regulations Supplement* (*DFARS)*, sub-part 207.4, paragraph 207.401. A copy of the lease/purchase analysis will be kept in the leased-equipment file.

c. **Authorization of Property**: Property authorizations serve as the authority (but not funding source) to requisition and retain equipment to perform directed missions. Commanders will ensure all property acquired from whatever source, to include excess, will have the proper authorization and justification documents developed and in place prior to obtaining the property.

d. **Authorization Documents:** The authorization document is the basis and authority for submitting requisitions for authorized equipment listed in the document. The property book will reflect this authorization. Non-expendable personal property acquired for use within USAMEDCOM will use the following authorization documents:

(1) A TDA is a document that prescribes the organizational structure, personnel, equipment authorizations and requirements of a command. **Procedures for modifying a TDA are contained in Appendices C and D** (*MEDCOM Guide to TDA Changes/Equipment Authorization, and Annex A & B*). *AR 71-32* governs TDAs. A TDA consists of the following three sections:

Section I: General, describes summary of manpower/equipment, the mission, organization, capabilities, and other general information pertinent to the unit.

Section II: Personnel Allowances, reflects the types and quantities of civilian and military expertise at paragraph and line level of detail. It includes position titles, MOS, grade/rank, identity code, branch code requirements authorizations, and remarks codes.

Section II: Equipment Allowances, documents at the LIN level detail, the controlled and non-controlled Army-adopted items of equipment having a standard LIN in *SB 700-20*, except for CTA items listed in Chapter 8. LIN, generic nomenclature, and the required and authorized quantities identify equipment allowances.

(2) The Common Table of Allowances (CTA) is an authorization document for items of materiel costing less than $100,000 required for Army-wide use. The purpose of the CTA is to authorize widely used items of relatively low-dollar value in one document rather than documenting the items separately in each TDA. Items authorized by a CTA will not be further documented in the TDA. CTA items can be authorized for various purposes and are addressed in:

CTA 8-100, Army Medical Department Expendable/Durable Items
CTA 50-900, Clothing and Individual Equipment
CTA 50-909, Field and Garrison Furnishing and Equipment
CTA 50-970, Expendable/Durable Items (except Medical, Class V, Repair Parts and Heraldic Items)

(3) Non-expendable property authorized in *CTAs 50-900* and *50-909* will be accounted for on property books as prescribed in *AR 710-2,* paragraph 2-5. Include the appropriate LIN from the cited CTA in the authorization information.

(4) Printed or hard copies of these CTAs are no longer available through publications channels. Electronic versions of these publications are located on the U.S. Army Force Management Support Agency (USAFMSA) web site at: **http://www.usafmsa.army.mil/usafmsa/**.

(5) As a general rule ARs are not equipment authorization documents; however, the regulations listed below are exceptions. Listed with each regulation and directive is a brief description of the equipment the regulation authorizes. The regulations and directives listed below can be used as authorization on the property book:

(a) *AR 1-100*, *Gifts and Donations*, 15 Nov 83. Donated, conditional or unconditional gifts of tangible personal property.

(b) *AR 25-1*, *Army Information Management*, 31 May 02. Non-investment systems or equipment for authorized visual information activities.

(c) *AR 40-61*, *Medical Logistics, Policies and Procedures*, 28 Jan 2005. Medical equipment and supplies not listed in Chapters 2, 4, or 6 of *SB 700-20*. Medical equipment assigned a LIN and listed in the above document must have TDA authorization.

(d) *AR 70-6*, *Development, Test, and Evaluation Army Appropriation,* 16 Jun 86. Research, Development, Test, and Evaluation (RDTE) property.

(e) *AR 600-8-22*, *Military Awards*, 25 Feb 95. Trophies and similar devices. (See Chapter 10).

(f) *AR 608-4*, *Control and Registration of War Trophies and War Trophy Firearms,* 28 Aug 69. War trophies and war trophy firearms.

(g) *AR 725-1*, *Special Authorization and Procedures for Issues, Sales and Loans*, 17 Oct 03. General officer pistol and flag.

(h) *AR 840-10*, *Flags, Guidons, Streamers, Tabards and Automotive and Aircraft Plates*, 1 Nov 98. Flags, guidons, plates, and tabards.

(i) *AR 870-20*, *Museums, Historical Artifacts, and Art*, 1 Nov 99. Historically significant items such as weapons, military equipment, flags, or articles of uniform or personal equipment.

(j) Local Commander Authorized Approval. This is an authorization for personal property item that is not covered under above sources, not qualified for inclusion on the TDA, and is required by the command. It will be identified on the property book using equipment authorization "*AR 71-32*".

5-2. EQUIPMENT RECEIPT PROCESSING

a. All accountable property items will be processed through the organization's PBO so that the control and accountability for the property can be established and maintained.

b. When accountable property is received, the PBO will:

(1) Update the property records. File the receipt document in the supporting document file to support the increase to the property accounting records. Submit a work order to the medical maintenance branch for a Technical Inspection (TI) of all medical equipment. Medical maintenance personnel will perform a TI of the equipment to ensure the delivered equipment is in compliance with the specifications of the contract, and is operational and safe for patient use. Attention to detail should be given to this process as some equipment may require vendor installation and any package opened may void the contract. A complete TI, if possible, will be performed within four (4) workdays of receipt of the work order by medical maintenance. Upon release of the equipment by medical maintenance personnel, arrange for delivery to the using activity and obtain the hand receipt holder/ custodian's signature on the hand-receipt transaction register/custodial actions list or DA Form 3161 if equipment is issued before the hand receipt transaction register/custodial actions list is produced. Equipment requiring an extended storage period before installation or acceptance will remain the custodial responsibility of the PBO until installation and acceptance are completed.

(2) File the signed copy of the hand receipt transaction register/custodial actions list or DA Form 3161 in the applicable hand receipt/property custodian file. Destroy this copy when the item appears correctly on the hand-receipt/custodian-receipt/locator list and the hand-receipt-holder/custodian has signed it.

c. No equipment will be delivered directly to the end user. However, should delivery occur, the end user/hand-receipt holder/custodian is required to notify the PBO immediately. Local instructions will be published to inform customers of this requirement. The PBO will coordinate the proper receipt and inspection with the appropriate supply support activity and medical maintenance, if applicable.

d. Receipts for the accountable property must be posted to the property records within three working days of receipt of the item. The three working days begin when Property Management personnel physically receive the item as signified by the date the receiving document is signed. No delay in the receiving process is authorized for technical inspection of the equipment either by the vendor or Medical Maintenance Branch.

e. Concern for voiding a manufacturer's warranty as a result of opening packages to obtain receipt data is not reason for delay in posting items to the property book. While it is important not to unpack equipment prior to the arrival of a vendor who is contractually bound to assemble or install the equipment, this does not prevent recording the receipt of the equipment. Information from the receipt document or packing list accompanying the equipment should be used to process an initial receipt. When the vendor installs the equipment, the initial receipt can then be adjusted with the actual data required to properly account for the item on the property book. In this way, both accountability and responsibility for the equipment are established without invalidating the warranty. The longer equipment

remains unaccounted for at an activity, the higher the probability for theft, diversion, or misappropriation.

5-3. DEFENSE MEDICAL LOGISTICS STANDARD SUPPORT (DMLSS) PROPERTY RECORD ADMINISTRATIVE ADJUSTMENT REPORTS

a. Property Record Administrative Adjustment (PRA) reports are automatically generated by Defense Medical Logistics Standard Support (DMLSS) when transactions are processed to change the serial or stock number of an item. The report documents minor changes used to adjust or correct property record deficiencies. The PRA report will not be used as a substitute for financial liability investigations of property loss or other adjustment documents when the possibility of physical substitution or actual loss of property exists.

b. The PRA reports produced by DMLSS will contain a document number with a Julian date equal to the current date and DMLSS assigned serial number. The DMLSS assigned document number will be used to record and file the automated PRA report.

c. The PBO and the Chief of Logistics will sign the last page of the PRA report indicating a review and concurrence of actions taken. The report contains only minor property adjustments; therefore, there is no need for command review or approval. Once signed, the PRA report is filed in the supporting document files. Supporting document files contain all documents supporting entries to the accounting data record in the property book and must be maintained for 6 years in accordance with *AR 710-2*, paragraph 2-5o and 2-5r.

5-4. HAND-RECEIPT HOLDER/CUSTODIAN PROCEDURES

a. Acceptance of and relief from custodial responsibility for accountable property will be accomplished as follows:

(1) When hand-receipt/custodial responsibility is to be assumed, the PBO will provide the hand-receipt holder/custodian with a Hand-Receipt/Custodian-Receipt/Locator Listing showing all property charged and due in to the hand-receipt/custodian account. Upon signing and dating the listing, the hand-receipt holder custodian assumes responsibility for all in-use items in the quantities indicated and verifies the requirement for all due-ins on the listing. The hand-receipt-holder custodian will return the original signed listing to the PBO and retain a signed copy as a record of equipment authorized and on hand or due in. As items are issued to or turned in from the account, the hand-receipt holder/custodian will keep a signed hand-receipt transaction register/custodian action list or DA Form 3161 showing the action taken, until the item is correctly listed on the applicable hand receipt/ custodian-receipt/ locator list at which time it may be destroyed.

(2) The hand-receipt holder/custodian will ensure, by spot check and periodic inventory, that all property in the account is properly charged to the account, is physically on hand, or that appropriate action has been taken to effect settlement for missing or damaged items.

(3) Before a hand-receipt holder/custodian is relieved from duty, transferred, separated from service, or absent from the account for a period longer than 30 days, the PBO will transfer the property to an authorized successor. The hand-receipt holder/custodian will not be relieved of property accountability responsibility until officially cleared by the PBO.

b. Contractors or contractor's personnel shall not be hand-receipt holders/custodians for equipment listed on a USAMEDCOM activity's property books. A contractor can only have responsibility for specifically identified Government Furnished Property (GFP) provided to the contractor under the terms of the contract.

c. Annual Property Inventory.

(1) All property will be inventoried annually by the hand-receipt holder/custodian in coordination with the PBO. The PBO will establish a schedule with which to complete the

inventory, conduct training, ensure bar code scanners are used, and accomplish the automated reconciliation process available in DMLSS to determine discrepancies between the physical inventory and the property book.

(2) Hand-receipt holders/custodians will use bar code scanners to scan all property, conduct a thorough physical area search for any non-expendable property not bar coded. Record the results of the inventory including any overages or shortages on a memorandum. The hand-receipt holder/custodian will sign the memorandum. The original copy of the memorandum is filed in the hand-receipt/custodian receipt/location list file maintained by the PBO. The hand-receipt holder/custodian retains the duplicate copy.

(3) The PBO will review all inventory memorandums submitted by hand-receipt holders/custodians for completeness and conduct causative research of any discrepancies. Causative research includes but is not limited to, comparing all postings to the applicable property book records against documents that support those postings, verifying all hand-receipt/custodian receipt/location listing change documents, and searching storage areas controlled by the PBO. A Financial Liability Investigation of Property Loss will be initiated and properly adjudicated for any property losses that cannot be reconciled. Establish property-book accountability for un-reconciled overages using “found on installation” procedures.

5-5 PROCEDURES FOR MANAGING AND CONTROLLING DURABLE ITEMS/EQUIPMENT

a. Durable property is personal property that is not consumed in use, does not require formal property book accountability, and does not lose its identity upon use, but because of its unique characteristics requires control when issued to the user. Examples of durable property are provided below:

Answering Machine	Manikin (Not medical-maintenance significant)
Cabinet, Storage	Microwave
Calculator	Mobile Cart
Camcorder	Mobile Hanging File
Camera	Overheard Projector
Cart, Utility	Radio, Portable, VHF
Cassette Recorder	Radio, Two-Way
Cassette Tape Player	Refrigerator, Household
CD Player	Sewing Machines
Chair, Executive	Slide Projector
Chair, Swivel	Sofas
Coffee Maker	Stapler, Heavy Duty/Electric
Conference Room Table	Telephone with Answering Machine
Date/Time Stamper	Telephone, Cordless
Drill, Electric/Portable	Typewriter
Dryers	Uninterruptible Power Source
Filing Cabinets	Vacuum Cleaner
Folding Chairs	Video Cassette Recorder
Freezer, Household	Wall Lockers
Hand Truck	Washers
Table Office	Water Fountain, Portable
Magnetic Scheduling Board	

Exceptions to this are:

(1) Property that is classified, and/or sensitive.

(2) Property that is medical-maintenance significant.

(3) Leased, rented, historical, heraldry or negotiable media.

(4) Automated Data Processing Equipment (ADPE); defined as laptop computers, notebook computers, central processing units, printers, digital assistants (DA), and communications equipment.

(5) Items listed on the Table of Distribution and Allowances (TDA).

(6) Test, measurement, and diagnostic equipment requiring calibration.

(7) The above items ((1) – (6)) will be accounted for as non-expendable regardless of their acquisition cost. Because of its unique characteristics and the nature of the item, it must be controlled and responsibility assigned when issued to the user.

b. Responsibilities

(1) The Commander is responsible for conducting an annual management review of all on hand durable items per *AR 735-5*, paragraph 7-6, to determine whether any items are missing, or for indications of fraud, waste, or abuse. The Commander will utilize the Logistics Division's Command Supply Discipline Program (CSDP) to conduct the management review of durable property. The CSDP will document the results and what corrective actions, if needed, were taken.

(2) *AR 735-5* reminds us that every supervisor has the obligation to ensure all Government property issued to or used by his or her subordinates is properly used and cared for, and that proper custody, safekeeping, and turn-in action promptly takes place.

(3) Since the supervisory position is a specific position on the TDA, some responsibilities cannot be delegated. For instance, the following supervisory responsibilities are inherent and are NOT contingent upon signed receipts or responsibility statements. Supervisors shall:

(a) Provide proper guidance and direction

(b) Enforce all security, safety and accounting requirements

(c) Maintain a climate that facilitates the proper care and use of Government property.

c. Durable Items/Equipment Accounting Procedures

(1) Each activity will establish a method to account for on hand durable items/equipment. You may develop your own accounting system or you may use one of the following management tools to track your durable items/equipment:

(a) Utilize Microsoft Excel software to create a spreadsheet that depicts each user by name and identify each piece of equipment by description, serial number, location, etc., in his/her possession/control. Be sure to gain the signature and date of each individual on the customized spreadsheet.

(b) Setup a manual system of manila folders by individual name. Prepare and issue equipment on the DA Form 2062, Hand Receipt/Annex Number (Sub-HR form) to each individual. Retain the original of the signed DA Form 2062 in the individual's respective folder.

(c) Develop a journal/register. Prepare and maintain equipment information as cited above and update as necessary.

(2) Whatever accounting system selected/developed, a clear audit trail of equipment acquisition to disposal must be maintained through the retention of various documents; such as issue, turn-in, or transfer documents. Each type of transaction document must be signed and dated by the individual. Update the documents as changes occur or at least quarterly. File and retain the documents for two years before destruction.

d. Annual Management Review Procedures.

(1) The Chief of Logistics will oversee the management review for the Commander; ensure supervisors throughout the facility are maintaining a durable hand receipt inventory in accordance with the above guidance and the Commander's guidelines. The CSDP, Logistics Division personnel will inspect activities to ensure compliance of the property accountability requirements for durable equipment. The following questions will be added to the existing CSDP checklist:

(a) Has there been any loss of durable items/equipment during the past twelve months? If yes, identify the nomenclature and quantity of the lost item(s).

(b) Was the supervisor notified of this loss? If not, why? Explain.

(c) Was the loss reported to the Provost Marshall and /or Security Guard force? If not, why? Explain.

(d) Was a Security Investigation Report completed?

(e) Was a DD Form 200, Financial Liability Investigation of Property prepared for the lost item(s)? If not, why? Explain.

(f) Is a file(s) maintained of the DD Form(s) 200 IAW *AR 735-5*?

(2) The logistics representative performing the CSDP inspection will provide the commander, thru the chief of logistics, a written report of the inspection results.

(3) The commander will annually certify the review of durable items/equipment by compiling the findings of the CSDP inspection results, and what, if any, corrective actions were taken, in a Memorandum For Record (MFR) format. This MFR, when signed by the commander, documents the annual management review of durable items.

(4) *AR 735-5*, paragraph 7-7b(3) outlines the commander's responsibility to perform and document the annual management review. The activity property book officer may not be designated to monitor the completion of the annual management review.

5-6. MONTHLY WEAPONS AND AMMUNITION INVENTORY

a. *AR 710-2*, Table 2-1j, prescribes monthly physical inventories of weapons and ammunition. Standard procedures for performing the inventory are in *DA Pamphlet 710-2-1*, paragraph 9-10. Specific procedures for USAMEDCOM activities are outlined in the paragraphs below.

b. The PBO will monitor and receive inventory results. As a minimum, the PBO will:

(1) Establish stringent controls on conducting inventories at least monthly (every 30 days). Provide the inventory officer with a serial number listing, either automated or a preprinted memorandum.

(2) Ensure all weapons and ammunitions inventoried are on the property book.

(3) Ensure completion of inventories for all weapons and ammunition on the property book.

(4) Reconcile ammunition expenditures with recorded property book balance.

(5) Confirm someone other than the responsible hand-receipt holder/custodian conducts the monthly inventory, and ensure the same individual does not conduct consecutive inventories.

(6) Take immediate corrective action to resolve all discrepancies.

(7) Retain copies of the monthly inventory reports on file IAW *DA Pamphlet 710-2-1*, paragraph 9-10b (4) (two years if no discrepancy noted; four years if a discrepancy was noted).

c. The individual(s) appointed to conduct the weapons/ammunition inventory will:

(1) Record the serial number of weapons inventoried and weapons properly checked out. Clearly distinguish between the two groupings. Notify responsible individual and PBO of any listed weapons you cannot locate, or which are not properly checked out. Weapons checked out should have a DA Form 3749, Equipment Receipt, in the arms rack. Installations/activities will maintain a current listing of all weapons not on hand because of repair.

(2) Record the ammunition inventoried by quantity, lot number, and NSN. Clearly highlight discrepancies noted during the inventory of both weapons and ammunition with information recorded on the memorandum or automated listing provided by the property book officer.

(3) Sign and date the inventory reports and forward the original copy to the PBO.

5-7. MANAGEMENT OF CAPITAL EQUIPMENT

a. Equipment that is defined as investment or capital equipment must be accounted for and reported for capitalization and depreciation in accordance with the Chief Financial Officer (CFO) Act of 1990 and the Federal Financial Management Improvement Act of 1996. USAMEDCOM is responsible for reporting medical investment equipment accounting information to DFAS annually for all USAMEDCOM activities.

b. Automated property accounting system user will adhere to their automated system's procedures when entering investment/capital equipment into the system.

(1) Depreciation of investment equipment is calculated in DMLSS, based on a straight-line depreciation method over a five-year life. Fully depreciated equipment will have zero depreciation at the end of the five years and will no longer be reported. The useful life of five years does not change the life expectancy for the equipment listed in *TB MED 7*.

(2) Original acquisition cost includes all costs incurred to bring capital equipment into service for its intended use. These costs include amounts paid to vendors, transportation to point of initial use, handling and storage costs, interest costs paid, direct and indirect production costs, installation costs, value of equipment traded-in, and training costs.

(3) Investment equipment acquisition date (in-service date) is the date when the title for the equipment passes to the Army or when the item is delivered to the Army or to an agent of the Army. Investment equipment acquired under a capital lease should be recorded as an asset at lease inception. For constructed assets, the "acquisition date" should be the date the asset is placed in service.

(4) Only add the value of upgrades/improvement costs if equal to or greater than $100,000.

(5) Transportation costs for lateral transfers must be added to the equipment CFO Record for a single piece of equipment or to the system line ("AA") if it is a system. Do not add it to the component lines. The losing PBO must request a copy of the Government Bill of Lading showing the transportation cost, shipping and handling from the Installation Transportation Office (ITO). For shipments containing multiple items, ask the ITO to list the costs of the individual items of equipment, if possible. If the ITO cannot provide the separate lines, then pro-rate the cost to each item by dividing the total cost equally among the items and input to the CFO Record. If the transportation cost is not available at the time of shipment, the losing PBO will, upon receipt of the transportation costs, adjust the equipment record. Print and fax a copy of the adjusted CFO Record to the gaining activity with the added transportation cost. The transportation costs are depicted on both property books, as a loss to the loosing activity and a gain to the receiving activity.

c. The Property Book Officer (PBO) is responsible for ensuring required source documentation is maintained for all capital equipment on hand. Capital equipment (including central purchases) will be supported by the contract (DD Form 1155), receiving report (DD Form 250), vendor invoice, and other sources that capture and document ancillary costs. Transferred capital equipment will be supported by the DD Form 1149/DA Form 3161, contract, receiving report, vendor invoice, and other appropriate documents. Figure 5- 1 outlines procedures the PBO must follow to locate the source documentation if not on file.

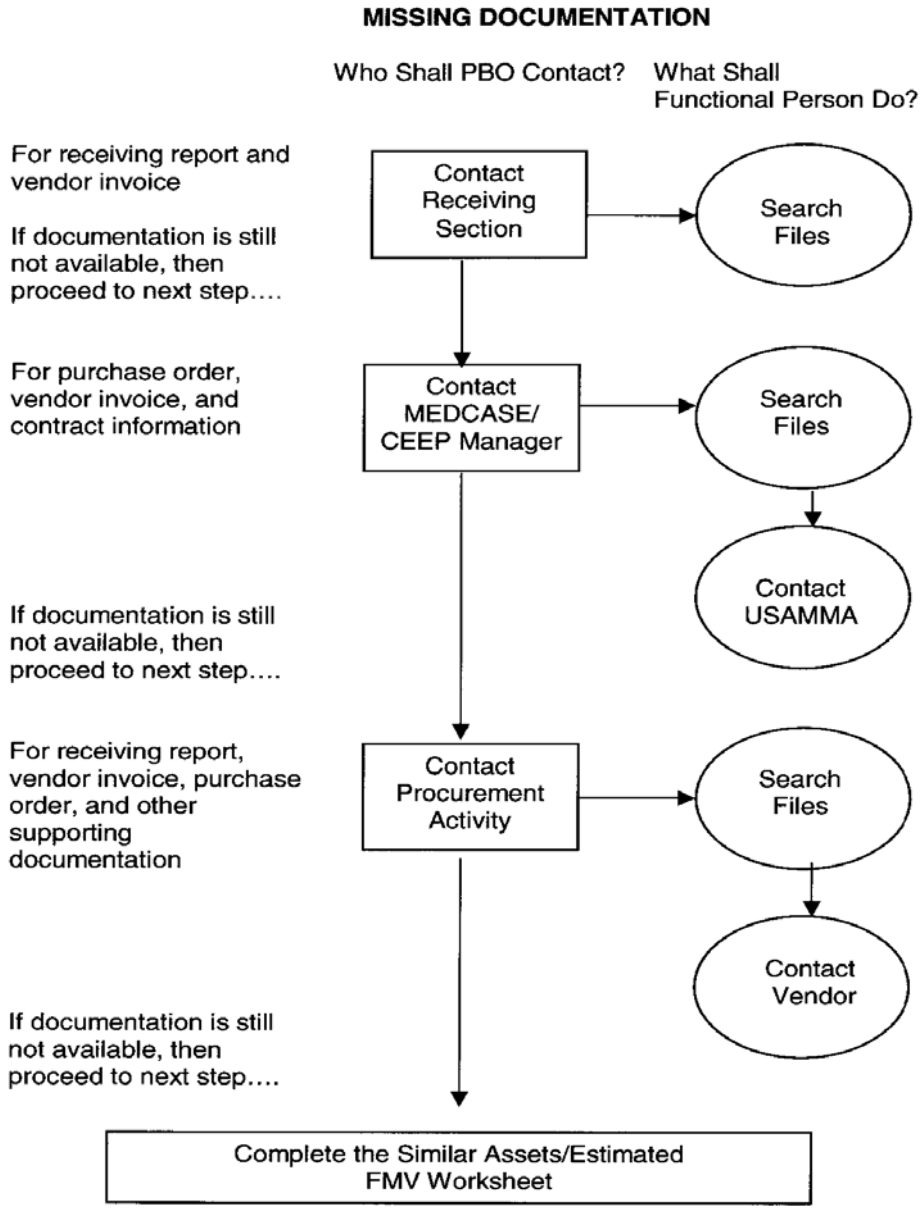


Figure 5-1

If the source documents cannot be obtained, the PBO will prepare a Similar Assets/Estimated Fair Market Value (FMV) Worksheet. A copy of the instructions and worksheet are Appendix A.

(1). Donated or found capital equipment will be supported by the Similar Assets/Estimated FMV Worksheet.

(2). Searching for source documentation or preparing the Similar Asset/Estimated FMV Worksheet is not required for fully depreciated equipment as of 1 October 2003.

(3) Acquisition cost estimates will be used only when the acquisition cost is unknown, source documentation is unavailable, and a similar asset exists. If a cost estimate is required for capital equipment item, the PBO will proceed as follows:

(a) Locate a similar asset using the property book database.
(b) Determine if the assets have similar model years.
(c) If the previous two criteria are met:
1) Obtain a copy of the supporting documentation and document on a Similar Assets/Estimated FMV Worksheet why the assets are comparable.
2) Review the documentation for cost information, specifications, and other pertinent information (method of acquisition, nomenclature, and description of function) to assign an acquisition cost. The estimated acquisition cost may be based on the following information:
a) The cost of similar assets at the time of acquisition, or
b) The acquisition costs of similar assets, taking into consideration changes in the Consumer Price Index between the date the item was acquired and the date the similar asset was acquired.

(d) If a similar asset cannot be located, determine the capital equipment's FMV from the vendor quote, the catalog price, or the GSA schedule. Document the information on the Similar Assets/Estimated FMV Worksheet.

(e) In the event the documents described above are not available, document the justification for the estimated FMV on the Similar Assets/Estimated FMV Worksheet.

d. When transferring capital equipment between property books, data required by the CFO Act must be entered on the applicable lateral transfer document (DD Form 1149 or DA Form 3161). Data elements required in addition to identification data elements are:
(1) Acquisition Cost – required.
(2) Residual Value – optional (only required if assigned by losing activity).
(3) Transportation Cost – optional
(only required if assigned by the losing activity).
(4) Improvement Cost – optional
(only required if assigned by the losing activity).
(5) Accumulated Depreciation – mandatory.
(6) Accumulated Improvement Depreciation – optional
(This is only required if assigned by losing activity. If there is an improvement cost there must be accumulated improvement depreciation.).

e. All documentation must accompany equipment when it is transferred. This includes the documents from the supporting document file, MEDCASE file and a copy of the CFO Record. Copies of supporting documentation shall be retained by the transferring activity; the originals are forwarded to the gaining activity. The gaining PBO must contact the losing PBO if this documentation isn't received with the equipment.

f. The lateral transfer loss is not removed from the loosing activity accountable records until a copy of the signed DD Form 1149 or DA Form 3161 is received from the gaining PBO.

g. Capital equipment leases are leases that transfer substantially all benefits and risks of ownership to the lessee. If, at its inception, a lease meets one or more of the following four criteria, the lessee should classify the lease as a capital lease.
(1) The lease transfers ownership of the property to the lessee by the end of the lease term.
(2) The lease contains an option to purchase the leased property at a bargain price.
(3) The lease term is equal to or greater than 75 percent of the estimated economic life of the leased property.
(4) The present value of rental and other minimum lease payments, excluding that portion of the payments representing executor cost, equals or exceeds 90 percent of the fair value of the leased property.

h. If the leased equipment meets any one of the four criteria for capital lease, identify it on the automated property records as such in accordance with the system procedures. The acquisition cost will be the actual cost of a like item or the fair market value if no like item is

available. An acquisition cost is required regardless of the type of lease. Leases not meeting the above criteria are classified as an operating lease. Operating leases are leases in which the activity does not assume the risks of ownership of the equipment. Multi-year service contracts and multi-year purchase contracts for expendable commodities are not capital leases.

i. Reporting and turn in of investment equipment is processed IAW *AR 710-2* and *AR 40-61*. All documentation will be transferred with the equipment when turned-in to the supply support activity or Defense Reutilization and Marketing Office (DRMO). The PBO will retain a copy of this documentation on file along with the turn-in documentation.

5-8. MANAGEMENT OF SYSTEMS AND COMPONENTS

a. Accountable property should be recorded on an item-level basis (i.e., each individual item in a separate record). However, when considered advantageous to do so or required to comply with capital equipment reporting requirements, records will be maintained on a system basis.

(1) The system method may be used when:

(a) Two or more individual items (equipment components) are part of a system; and

(b) The system is considered to be incomplete or inoperable in the absence of any one of its component equipment items.

b. DMLSS users will adhere to the following procedures to establish a system on the property book:

(1) Establish a “due-in” for the item in accordance with DMLSS procedures.

(2) Receive the system in accordance with DMLSS and local procedures. Identify this with an Equipment Type of “System”. This is an actual item and should be the major component of the system. Record the total cost of the system on this Equipment Control Number (ECN).

(3) Gain the other components of the system using the DMLSS ETM Gain module with the reason “Component Gain” and Equipment Type of “Component” with an acquisition cost of $0.00. Ensure the components are associated with the system ECN.

(4) Return to the system record and select the Acquisition Cost icon and adjust the purchase price to reflect the actual acquisition cost, installation cost, trade-in value, etc. The total cost of the system is recorded on the system line.

(5) Identify components requiring medical maintenance services. Update the catalog record to signify which components require maintenance services.

c. USAMEDCOM activities with Digital Imaging Network – Picture Archiving Communications Systems (DIN-PACS) will ensure the system and all components are properly accounted for in DMLSS. Device tracking is a requirement of JCAHO. Appendix B contains detailed procedures.

5-9. MILITARY MEDICAL BENEFITS PROPERTY (MMBP) LOAN PROCEDURES

a. Activities maintaining equipment accounting record using the DMLSS system will manage the Military Medical Benefit Property (MMBP) loans in accordance with the applicable system’s operating procedures.

b. Activities using manual equipment accounting records or an automated system without a specific MMBP loan process will account for and record MMBP property loans as follows:

(1) MMBP property will be listed on a separate hand receipt.

(2) MMBP property lent to a patient will be listed on DA Form 3161.

(a) Block 2 of DA Form 3161 will reflect the complete name, address, category, telephone number, and social security number of the borrower.

(b) DA Form 3161 will have, in addition to a listing of the equipment lent, the following statement:

> I hereby acknowledge acceptance of the above-listed Government–owned equipment received in good working order and repair, for temporary use. During the period (___enter date ___) to (___ enter date ___). I understand that I am responsible for proper care and safekeeping of the equipment and will promptly return it/them in the same condition as received, fair wear and tear expected, upon termination of the loan period specified unless an approved extension is obtained, or at such earlier date as I may elect. In the event of loss, damage or destruction of the equipment through fault or neglect, I agree to reimburse the Government the cost of repair or fair market value of the equipment as appropriate.
>
> I have been informed that periodic maintenance services are to be performed (insert frequency). Service is required (_____ enter dates _____). When feasible, it is my responsibility to transport the equipment to (_____insert HCA_____) to obtain the required services. Prior arrangements by telephoning (___number___) for services should be made. If I relocate to another area and will receive medical care from another Federal health care facility I must notify (___ insert property manager _____) so that equipment transfer can be accomplished and designation of a new supporting maintenance activity can be established.
>
> It is further understood that the equipment on loan is not to be permanently removed from the address indicated in block 2 of the hand receipt without prior authorization of the commander (name of the HCA).
>
> _____(Signature of patient or sponsor)_____

(c) DA Form 3161 will be prepared in duplicate and signed by the patient or sponsor accepting the loan. The MMBP manager will keep the original copy with the written prescription or letter. The second copy will be given to the borrower.

(d) MMBP Reconciliation: The physical inventory of MMBP equipment on loan is not required. However, equipment on loan will be reconciled each year to verify the accuracy of property book and hand receipt balances. Reconciliation may be accomplished telephonically or by certified mail. If all efforts to reconcile lent MMBP property fail, obtain relief from property accountability through procedures in *AR 735-5*.

5-10. OXYGEN FOR HOME USE

Oxygen and oxygen-related supplies that are provided to outpatients for home use may be provided pursuant to the availability of funds by one of the following methods:

a. The HCA may contract with a local oxygen supplier to provide complete home service. This service should include safety and operating instructions, gas cylinders, tubing, regulators, maintenance, and all other related supplies.

b. When a HCA does not contract for home oxygen service, government-owned cylinders and equipment may be provided for outpatient use. If this method is used, follow these guidelines:

(1) Establish local procedures to provide safety, operating, and refill procedures as well as tubing, regulators, and other necessary supplies.

(2) Establish procedures for medical maintenance to inspect regulators and other oxygen related equipment prior to issue or loan to the patient, during home use, and upon return of the equipment to the HCA.

5-11. ORGANIZATIONAL CLOTHING AND INDIVIDUAL EQUIPMENT (OCIE) WAIVER PROCEDURES

a. All USAMEDCOM activities/units located on an installation with a Central Issue Facility (CIF) must seek and obtain OCIE support from the supporting CIF. Coordination should be made with the supporting CIF to transfer on-hand property book OCIE items and determine specific method of support; support levels and means or reimbursement must be documented on an Installation Support Agreement. When the activity/unit is not located on an installation, or located on an installation without a CIF, and the distance is such as to cause significant inconvenience/hardship, the activity/unit must request authorization to maintain OCIE as an exception to policy.

b. The request must explain why installation support is not used. Along with the request for an exception to policy, the activity/unit must submit its written operating procedures for the unit OCIE Issue Point in accordance with *AR 710-2*, *DA Pamphlet 710-2-1*, and *AR 735-5*. The exception to policy must be submitted through formal channels beginning with the applicable RMC or MSC through USAMEDCOM to the DA. The USAMEDCOM will review and submit to DA (for approval/disapproval) only those exceptions to policy, which meet the criteria identified above.

c. Commanders authorized to maintain OCIE on their property books will follow procedures described in *DA Pamphlet 710-2-1*, Chapters 4 and 10, to account for and assign responsibility of OCIE, respectively.

5-12 LATERAL TRANSFER PROCEDURES

a. Activities may laterally transfer excess equipment with a unit price less than $350,000 without reporting it as excess if they have identified a gaining activity. Activities will report excess equipment command wide if they cannot find a gaining activity.

b. The losing activity commander signs the lateral transfer document as the approving authority. The RMC can withdraw or modify lateral transfer authority from its activity commanders. The RMC commander can supplement these lateral transfer procedures as they see appropriate.

c. The losing activity should ship equipment to the gaining activity within three weeks of disposition instruction receipt. The gaining activity is responsible for all shipping costs. Equipment will be shipped in accordance with *AR 746-1*. Ensure equipment is properly packed, crated, and shipped. Activities receiving damaged equipment will attempt to resolve the situation at their level.

d. Laterally-transferred equipment will include:

(1) Supporting supplies (expendables) and accessories on hand.

(2) Supporting repair parts and listing(s) on hand.

(3) Operator's manuals, manufacturer's literature, and technical manuals.

(4) The maintenance history/records to include the work order requesting the excess technical inspection for condition code. Activities using DMLSS to account for their property will send the Historical Maintenance Report and the Equipment Detail Report. Both reports are printed from the Equipment Management equipment detail window.

(5) CFO files when applicable.

e. The gaining activity establishes property accountability upon receipt and will return the signed lateral transfer document within three (3) days of receipt. They acknowledge receipt by returning the original signed copy of the lateral transfer document to the losing activity. The losing activity will place the signed copy of the documentation for the lateral transfer in the supporting document files.

5-13. EXCESS PROPERTY PROCEDURES

a. Efficient and prudent logistics management is more than getting the right equipment to the right place at the right time; it also includes eliminating redundant or excess equipment. Annually, the Army spends an enormous amount of time, labor, and money maintaining and storing excess equipment. These expenses are avoidable. Effective and efficient utilization and disposal of excess equipment is one of the most important phases in life-cycle management. Every facility benefits from timely and proper disposal of excess property because:

- timely disposal makes property available to the entire DoD.
- you may be able to reduce costs by using other facility's excess equipment.
- disposal of excess equipment reduces the time needed to locate unused equipment during required inventories and for maintenance services.
- you are properly prepared for any audit.

(1) The objective for each property book is to have no more than 3% (equipment items and/or property book value) as excess.

(2) Each activity will establish controls to ensure that all hand receipt holders/custodians continually evaluate the need for assigned equipment. Hand-receipt holders/custodians will retain only that equipment necessary to perform the assigned functions. When excess equipment is identified, it will be turned in for reassignment or disposal as excess.

(3) Equipment determined to be excess to an activity is transferred to the designated excess hand-receipt/custodian location list in accordance with automated property book system procedures. A technical inspection/classification will be initiated by the property book officer within 15 days of the date the equipment is turned-in as excess. It is essential that an accurate condition code be assigned to all equipment prior to it being reported as excess. This equipment is redistributed directly from one activity to another based on the reported condition code. The credibility of this program is a direct result of the reporting activity's ability to correctly identify the condition of each piece of equipment.

(4) Equipment turned in that is neither serviceable nor economically repairable due to normal usage will be disposed of in accordance with *DoD Regulation 4160.21-M* within 30 days of turn-in.

(5) Serviceable/economically repairable equipment will be advertised to internal customers. The property book officer will broadcast the availability of excess equipment to internal sections and staff using standard departmental e-mail, posted lists and/or routed notices. Excess equipment not re-distributed internally will be reported as excess within 30 days of excess determination in accordance with automated property book procedures. The 30-day time limit starts on the date of transfer to the excess hand receipt/custodian location list.

b. DMLSS Reporting And Requesting Materiel Through The Tri-Service Medical Excess Distribution System (TRIMEDS)

(1) All excess reported by DMLSS sites is posted daily on the TRIMEDS website: https://afml.ft-detrick.af.mil/afmlo/TRIMEDS/main.cfm . Users can browse the website at their convenience. Air Force as well as Army excess is advertised on this site and is available to all three services. The reporting criterion for excess equipment is as follows:

- Total minimum line item value is $250.
- Condition Codes A, B and C are the only acceptable codes.

(2) Excess will be advertised for 45 days through the TRIMED website. Army excess will be available to Army activities only for the first 20 days and all other eligible requesters for the remaining 25 days. The gaining activity is responsible for coordinating the acquisition of excess equipment. The gaining activity is responsible for all shipping costs.

(3) Activities should screen the TRIMED website excess list closely for items that can be used in their activities. Pay particular attention to condition codes and dates. When requesting equipment items, the Medical Maintenance at the requesting activity should contact the Medical Maintenance at the reporting facility to determine if the equipment can meet the requesting activity's needs.

(4) Gaining activities that receive discrepant shipments or do not receive a shipment within normal pipeline time for the mode of transportation used will notify the reporting activity in writing requesting an explanation for the delay or explaining the discrepancy. File a copy of the written notice with the receipt document.

(5) Reporting activities not receiving redistribution instructions by the end of the 45-day advertisement period will initiate a turn-in to the DRMO in accordance with *DoD 4160.21M*. Turn in will be accomplished within 30 days of the end of the advertising period.

CAUTION. Excess property may not be provided to governmental agencies outside DoD such as the DVA, Public Health Service (PHS), Indian Health Service (HIS), or to state and local governments, or civilian concerns without prior screening by USAMEDCOM activities, other Army activities, and DoD, and without going through the local DRMO. DRMO is the official conduit for transferring DoD excess property to any agency outside DoD. Assistance may be obtained from the local DRMO.

c. Turn-in Procedures

Equipment reported and not being transferred to another activity or is unserviceable, and cannot be economically repaired, may be turned-in directly to the DRMO. Turn-in procedures are as follows:

(1) The PBO shall prepare a DD Form 1348-1A (Issue Release/Receipt Document) in accordance with *DoD 4160.21-M*.

(2) The property and a properly prepared DD Form 1348-1A will be taken to DRMO where the document is stamped/signed to verify receipt. An unsigned/unstamped (by DRMO) DD Form 1348-1A is not acceptable as a supporting document for the loss.

(3) The equipment will be removed from the property book following the automated procedures for the applicable system.

(4) Periodically, the PBO shall obtain a listing of all equipment received by DRMO from his/her activity and compare that listing to activity records to ensure that all items sent to DRMO were properly documented and processed in the property system. The PBO should resolve any errors within 5 business days. The reconciliation records should be maintained in the property records until the next reconciliation.

5-14. PROPERTY BOOK CLOSEOUT PROCEDURES

The U.S. Army Medical Command (USAMEDCOM) MSCs are responsible for verifying the final closeout of property book(s) belonging to their subordinate units, installations and activities. The purpose of verifying closure of the property book is to validate the accuracy and completeness of the property book and supporting documents, to ensure that all property-book- recorded assets have been properly disposed of, and that all open requisitions have been cancelled or a new ship to address is reflected in the logistics records. The verification process will be performed by an individual (verifying officer) from an organization other than whose property book is closing out. When a property book is to be closed, the following guidelines are given:

a. The MSC Commander will advise the unit/installation/activity commander, in writing, of the effective date and the reason for the closeout. One copy of this notification or other pertinent orders will be filed with the property records.

b. The PBO will conduct a complete physical inventory of property recorded on the property book and either laterally transfer those assets to another property book or turn in those assets to the supporting stock record account or Defense Reutilization and Marketing Office (DRMO). The property book will reflect these transactions. The intent is to bring each record on the property book to zero balance prior to the close out effective date.

c. The unit/installation/activity inactivating will submit requests for cancellation of those requisitions for all supply classes not expected to be consumed prior to the inactivation effective date. The common sense rule applies. The document register should reflect these actions. When verification of the cancellation request is not received the request for cancellation will serve as the supporting document to close the property book.

d. Request cancellation of the property book DODAAC once all property book records are reduced to zero.

e. The verifying officer will:

(1) Initiate the verification process within 10 workdays after all property book on hand balances are reduced to zero.

(2) Include as part of the verification process that;

(a) The recorded balance on each property record was properly brought to zero balance through turn-in or lateral transfer procedures.

(b) Documents listed on the document register have a corresponding hard copy supporting document on file.

(c) All open supply requests are canceled.

(d) The non-expendable document register is closed.

(e) The assigned property book DODAAC was cancelled.

f. Since it is not likely that all line items on the unit's property book can be verified, the verifying officer must take a sample. The size of the sample should not necessarily be a set percentage (10 percent, 15 percent, etc.) of the property book line items. The extent of this verification should depend on the results of recent inspections of the activities' property book. In other words, if significant discrepancies were disclosed, then a more extensive examination should be done. The line items selected for sampling should be selected on the basis of cost, sensitivity, desirability, or any other factor which may warrant inclusion. Since the examination will include only a portion of the total property book line items, it is critical that items selected for the sample have significance.

g. Upon completion of the property book closeout verification the verifying officer will report in writing to the commander that appointed the PBO that he/she has verified the property book has been closed out. When the accuracy and completeness of the property book cannot be verified, the verifying officer will recommend action under the provisions of *AR 15-6* or *735-5* to his/her appointing authority.

h. The commander that appointed the PBO will:

(1) If the property book close out cannot be verified, the commander will direct actions to correct any discrepancies. The notice of corrective action undertaken and estimated completion date will be sent to notify the MSC commander and this office,

CDR, USAMEDCOM
ATTN: MCLO (Property Management)
2050 Worth Rd. Ste 8
FT Sam Houston, TX 78234-6008

The PBO will not be relieved from accountability until all property has been accounted for.

(2) When satisfied that all required actions are completed and no formal audit, i.e., Criminal Investigation Division or *AR 15-6* investigation, is necessary, the commander will prepare a statement certifying all actions in paragraph (1) above are completed. Provide a copy to the MSC commander and this office at the following address:

CDR, USAMEDCOM
ATTN: MCLO (Property Management)
2050 Worth Rd. Ste 8
FT Sam Houston, TX 78234-6008

(3) Rescind the PBO's appointment.

Final disposition of documents supporting entries to the property book will be in accordance with *AR 25-400-2*.

CHAPTER 6. MEDICAL EQUIPMENT MAINTENANCE

6-1. MEDICAL EQUIPMENT MAINTENANCE PROCEDURES FOR TO&E UNITS

The medical equipment maintenance procedures for TO&E units are contained in *TB MED 750-2*, *Operating Guide for MTOE Medical Equipment Maintenance*, dated November 2006.

6-2. MEDICAL EQUIPMENT MAINTENANCE FOR MEDCOM TDA ACTIVITIES

Medical equipment maintenance procedures for MEDCOM TDA activities are contained in *TB MED 750-1* dated April 1998. *TB MED 750-1* procedures are further supplemented in this chapter of *SB 8-75-11*. The following chapter addresses:

a. 6-3 Contracting for maintenance services
b. 6-4 Statements of Work for Maintenance Contracts
c. 6-5 Commander's Maintenance Directive
d. 6-6 Policy for Medical Maintenance Activities
e. 6-7 Medical Maintenance Man-hour Accounting for Defense Medical Logistics Standard Support (DMLSS) Users
f. 6-8 Management of Non-Army Owned Medical Equipment
g. 6-9 Radiation Protection Program Files

6-3. CONTRACTING FOR MAINTENANCE SERVICES

a. The DSCP has negotiated maintenance service contracts with a number of vendors for the support of imaging equipment, physiological monitoring systems and digital imaging network - picture archiving and communications systems. The DSCP engineers and contracting personnel will help you obtain quality, comprehensive medical equipment maintenance services. The service programs are extremely flexible, permitting you to customize your maintenance requirements. The contracts can provide scheduled and unscheduled services, glassware, first-look options, plus 24/7 access to contractor services. All federally funded sites, CONUS and OCONUS, may use the DSCP contracts

b. Managers of MEDCOM maintenance activities will use the DSCP contracts as the primary source of contract maintenance support. For exceptions to the use of the DSCP contracts you must forward your complete proposed contracts to MEDCOM for approval. If approved, MEDCOM will forward your requested contract to Medical Command Contracting Agency for processing. Send your exception contracts to:

CDR USAMEDCOM
ATTN: MCLO O
2050 WORTH ROAD STE 8
FT SAM HOUSTON, TX 78234-6008

c. For additional information and/or assistance, you may contact the following offices:

DSCP Technical POC Imaging:
CDR DSCP: Technical POC Imaging
ATTN: DSCP-FSDB
700 Robbins Ave
Philadelphia PA 19111
DSN 444-0741, commercial 215-737-0741, FAX 215-737-5752/8002

DSCP Technical POC Physiological Monitoring Systems:
CDR DSCP: Technical POC Physiological Monitoring Systems
ATTN: DSCP-FSDA
700 Robbins Ave
Philadelphia PA 19111
DSN 444-2845, commercial 215-737-2845, FAX 215-737-8002

DSCP Technical POC DIN-PACS:
CDR DSCP: DSCP Technical POC DIN-PACS
DSCP-FSDB
700 Robbins Ave
Philadelphia PA 19111
DSN 444-3138, commercial 215-737-3138

DSCP Contracting POC:
CDR DSCP: DSCP Contracting POC
DSCP-FSDB
700 Robbins Ave
Philadelphia PA 19111
DSN 444-5753, commercial 215-737-5753, FAX 215-737-5752/8002

d. **MEDCOM POC is**:
CDR USAMEDCOM
ATTN: MCLO O
2050 WORTH ROAD STE 8
FT SAM HOUSTON, TX 78234-6008
DSN 471-7151.

6-4. STATEMENTS OF WORK FOR MAINTENANCE CONTRACTS

a. Annual and one-time maintenance service contracts are effective management tools when accompanied by a comprehensive Statement of Work (SOW) informing contractor service personnel what is required. Contractor service personnel are obligated to provide only those services delineated in the contract SOW. To ensure that maximum value is obtained from service contracts, maintenance managers should include the following clauses in the SOW for each contract as applicable:

(1) For Repair and Return. "Upon completion of services, a written service report shall accompany the equipment being returned. The service report shall provide detailed information regarding the cause of the equipment malfunction and corrective action taken. Include, at a minimum, the time required to compete the work, price of labor (hourly rate), and a list of parts replaced with prices for each part."

(2) For On-site Repairs:

(a) “Contracted services are to be performed during the month(s) of _____ and_____ (list the required months). Contractor is required to respond within (state hours/days) (during normal duty hours) (after duty hours/weekends/holidays).

(b) "Contractor's service representative shall report in person or telephonically notify the maintenance manager, Building No. __ (for the maintenance activity), Telephone No. _____, prior to commencing services during normal duty operating hours (state duty hours). During other than normal operating hours, the contractor's representative shall report to the Administrative Officer of the Day (AOD), Building No. _____ (for the medical treatment facility)."

(3) "The government and the contractor’s service representative will exchange hazard communication information before the commencement of any repair."

(4) "When required, the contractor’s service representative will comply with the Office of Safety and Health Administration lockout/tagout standards while performing maintenance on equipment."

(5) "Upon completion of services by the contractor's service representative, a written service report shall be provided to the maintenance manager or the AOD. The service report shall provide detailed information regarding the cause of the equipment malfunction and corrective action taken. Include, at a minimum, the time required to complete the work, price of labor (hourly rate), and a list of parts replaced with part numbers and prices for each part."

(6) "In the event all information is not available to the contractor's service representative when services are performed, the initial service report shall include all available information. The contractor shall provide the balance of the required information to the maintenance manager no later than 10 days after services are completed."

(7) "After performing Calibration/Verification/Certification services, the contractor's service representative will affix and/or update DD Form 2163 (Medical Equipment Verification/Certification). The contractor shall complete DD Form 2163 in accordance with the instructions provided in Technical Bulletin (TB) 38-750-2, or by the maintenance activity's internal SOP."

(8) "Contractor's service representative will be factory trained and have a minimum of two years of experience working on the contracted equipment."

(9) "Contractor must furnish all software upgrades issued by the equipment manufacturer."

(10) "Contractor shall have access to all necessary diagnostic software (if applicable)."

(11) For all contracts that require calibration of x-ray systems, include this statement: "The contractor shall complete DD Form 2164 (X-ray Verification/Certification Worksheet) in accordance with the instructions provided in TB 38-750-2. A continuation sheet shall be attached to the DD Form 2164 indicating the manufacturer, model, serial number, and date of calibration expiration of all items of test, measurement and diagnostic equipment used to perform the calibration".

(12) "Required forms and extracts from pertinent directives will be furnished to the contractor's service representative by the government."

b. If the contractor's calibration equipment produces a printed summary of the calibration procedure used, attach the printed summary to the DD Form 2164. Ensure that the heading of the DD Form 2164 is filled out and that the form is properly signed.

c. The maintenance manager will document unscheduled services performed under an annual or one-time service contract utilizing the work by other tab in the DMLSS maintenance module using the contractor's hourly rate and parts cost. Maintain service reports provided by the contractor in the contract files.

d. The maintenance manager will document scheduled services performed under an annual service contract using the automated maintenance system generated scheduled service transaction. Use an unscheduled work order transaction, with the applicable action code, when performance of scheduled services by the contractor occurs at an interval other than that for which the equipment item is normally scheduled.

e. Maintenance managers must ensure that all services performed under an annual or one-time service contract are captured in the maintenance data base.

Note: the maintenance manager is required to perform an economic analysis prior to initiation or renewal of any annual service maintenance contract. Economic analyses are also required for one-time service contracts.

6-5. COMMANDER'S MAINTENANCE DIRECTIVE

a. Commanders of U.S. Army Medical Command activities (MEDCEN/MEDDAC/U.S. Army Health Clinic/MRMC Research Activity) with organic medical equipment repair capability will publish a maintenance support directive. The Maintenance support directive will establish basic maintenance policies and responsibilities for the performance of the activities' maintenance mission.

b. At a minimum, the maintenance support directive will include maintenance program responsibilities for the following:

(1) Commander.
(2) Director of Logistics/Chief Logistics Division.
(3) Chief, Maintenance Branch/Equipment Management Branch.
(4) Supervisors of equipment operators.
(5) Equipment operators.

c. The directive should also:

(1) Establish the activity's program for the performance of scheduled and unscheduled services.

(2) Identify the individual(s) having authority to approve waivers of maintenance expenditure limits, with explanatory procedures for processing a request for a waiver.

(3) Identify the individual(s) authorized to initiate maintenance service contracts and delimiting who has authority to contact vendors for warranty and contract maintenance services.

(4) Require that medical maintenance be involved with all medical equipment procurements and that all regulatory requirements are met when new medical equipment items are requested and received by the activity.

(5) Define the procedure for handling non-government owned (rented/leased/cost per test/reagent contract) patient care and diagnostic medical/laboratory equipment to comply with regulatory guidance and accreditation agency requirements.

(6) Define the commander's policy for handling items of medical equipment that cannot be located for the performance of scheduled maintenance services.

6-6. POLICY FOR MEDICAL MAINTENANCE ACTIVITIES

a. Field Maintenance (formerly unit and direct support maintenance). Maintenance of Army Medical Department equipment will be as follows:

(1) Perform field maintenance locally IAW *AR 750-1*, *AR 40-61*, and *TB MED 750-1*.

(2) All MEDCOM maintenance facilities may perform field maintenance. This includes overhaul if it is within the unit's capabilities.

(3) If appropriate, contact the U. S. Army Medical Materiel Agency-National Maintenance Point (USAMMA-NMP) for maintenance support for the repair and return of economically repairable medical equipment that cannot be repaired locally. Your point of contact at USAMMA is available at DSN 343-4365 or commercial 301-619-4365.

(4) Prior to the use of any commercial maintenance source, determine that no other government facilities are available. Perform an economic analysis to ensure that commercial repair is the most cost effective method to use.

(5) Satellite Units dependent on stations or other larger units for medical supply support will ordinarily receive medical maintenance support from the same source on a non-reimbursable basis.

(6) Establish comprehensive preventive maintenance programs for all medical technical equipment requiring periodic service and/or repair. Installations and activities will vigorously pursue these programs.

(7) Perform inspection and testing programs for medical electrical or electronic equipment safety IAW the standards of the *National Fire Prevention Association Standard for Health Care Facilities* (*NFPA 99*) and command guidance.

(8) Program, accomplish, and document calibration, verification and/or certification of medical equipment as required by directives and/or manufacturers' recommendations.

(9) Schedule and perform scheduled parts replacement in accordance with manufacturers' recommendations.

(10) The MEDCOM MEDCENs, medical department activities (MEDDACs), and other MEDCOM activities with medical equipment maintenance capability, will provide medical equipment maintenance support within their geographical area of responsibility as follows:

(a) On a scheduled and requested basis to non-MEDCOM Active Army activities without an authorized organic medical equipment maintenance capability. On installations with non-MEDCOM tenant units possessing organic medical equipment maintenance capability, MEDCOM maintenance activities will provide support **only after** all existing non-MEDCOM unit maintenance assets have been exhausted.

(b) As requested for other non-MEDCOM Active Army activities with an authorized organic medical equipment maintenance capability. On installations with non-MEDCOM tenant units possessing organic medical equipment maintenance assets, provide support only after all existing non-MEDCOM unit maintenance assets have been exhausted.

(c) As requested for U. S. Army Reserve (USAR) to the extent that requirements permit and if capabilities and capacities exist.

(d) As requested for Army National Guard (ARNG) to the extent that requirements permit and if capabilities and capacities exist.

(e) As requested for other DoD and Federal government agencies to the extent that requirements permit and if capabilities and capacities exist.

b. Reimbursable and non-reimbursable policy. Reimbursement policy (Enclosure) for medical equipment repair parts and other medical equipment maintenance services provided non-MEDCOM activities is as follows:

(1) Repair parts.

(a) Medical repair parts issued by the installation medical supply activities (IMSA) to any activity are reimbursable. The MEDCOM medical equipment maintenance activities will not issue repair parts to any activity.

(b) Provide medical repair parts used by MEDCOM medical equipment maintenance activities when performing unit or direct support maintenance on medical equipment belonging to any Active Army unit on a non-reimbursable basis. This includes Operation and Maintenance Defense (OMD) or Operation and Maintenance Army (OMA) funded units.

(c) Medical repair parts used by MEDCOM medical equipment maintenance activities when performing unit or direct support maintenance on medical equipment belonging to any other activity other than identified in paragraph (2) above are provided on a reimbursable basis.

(2) Labor costs.

(a) Military and civilian labor costs for the support of the Active Army are not reimbursable.

(b) Military and civilian labor costs for the support of ARNG are reimbursable.

(c) Military labor costs for the support of USAR, DOD, and other Federal agencies are not reimbursable.

(d) Civilian labor costs for the support of USAR, DOD, and other Federal are reimbursable.

(3) Reimbursable maintenance cost policy. When the reimbursable maintenance costs (parts cost plus applicable labor cost) are less than $100 per calendar quarter, the reimbursement will be waived.

(4) Temporary duty (TDY) expenses.

(a) The TDY expenses to support Active Army OMD or OMA funded organizations medical equipment are not reimbursable.

(b) The TDY expenses to support any activity other than those in paragraph (a) above are reimbursable.

REIMBURSEMENT POLICIES (Summary Table)				
ITEM	**ACTIVE ARMY**	**OTHER DOD**		
		USAR	ARNG	AGENCIES
REPAIR PARTS ISSUED BY IMSA	YES	YES	YES	YES
REPAIR PARTS UTILIZED ON WORK ORDER	NO	YES	YES	YES
MILITARY LABOR	NO	NO	YES	NO
CIVILIAN LABOR	NO	YES	YES	YES
TDY EXPENSES	NO	YES	YES	YES
NOTE: Total maintenance costs (parts cost plus applicable labor cost) more than $100 for any non-OMA funded activity are reimbursable				
TDY EXPENSES to support all activities other than active Army are reimbursable				

c. Maintenance services.

(1) Ensure that equipment density lists and scheduled services lists are developed and maintained IAW *AR 40-61*, *TB MED 750-1*, and DMLSS procedures.

(2) Provide admin/support services in support of radiation surveys, the MEDCASE program, and other programs as required.

(3) Provide supportive maintenance services to other MEDCEN/MEDDAC activities as prescribed by other command directives.

d. Performance objectives of the maintenance activities are to:

(1) Support medical equipment necessary to sustain the high standards of health care IAW policies stated in *AR 40-61* by providing:

(a) Effective and timely repair services.
(b) Cyclic preventive maintenance.
(c) Inspections and/or electrical safety testing.
(d) Calibrations.
(e) Scheduled parts replacements.
(f) Efficient utilization of maintenance personnel.

(2) The MEDCOM objective is to complete 100 percent of those services scheduled during any monthly maintenance cycle. The MEDCOM minimum acceptable performance levels for the completion of all services scheduled each month are as follows:

(a) Calibration 95 percent
(b) Preventive maintenance 95 percent
(c) Safety tests 95 percent
(d) Scheduled parts replacement 95 9ercent

(3) Manpower utilization is a ratio of direct labor manhours actually expended on the maintenance workload (scheduled and unscheduled work orders) expressed as a percentage of the total net hours available for maintenance.

(4) The MEDCOM acceptable range for the utilization of personnel is between 95 percent and 100 percent. If your utilization factor is less than 95 percent or greater than 100 percent, you must analyze your personnel usage and take any needed corrective actions required.

e. Backlog. Work order backlog is defined as those received work orders for which repair work has not been completed.

(1) Generally, a 5-day backlog is considered nominal. A backlog in excess of 5 days may indicate an existing problem with work-order processing. Management should investigate to determine the reason for the excessive backlog.

(2) The nominal 5-day workload is determined by dividing the monthly average jobs completed for the previous 6 months by 4.2.

6-7. MEDCIAL MAINTENANCE MAN-HOUR ACCOUNTING FOR DEFENSE MEDICAL LOGISTICS STANDARD SUPPORT (DMLSS) USERS

a. The DMLSS Maintenance Management Report (MMR) is one of the critical tools a maintenance manager has to evaluate the overall performance of his/her maintenance program. An MMR that contains inaccurate data, or is missing data, is of limited value and reflects unfavorably on the maintenance manager and his/her staff.

b. The following paragraphs contain mandatory requirements, suggestions, and information to assist management personnel to correct and/or improve the quality of man-hour accounting data appearing on your MMR.

(1) Each medical maintenance activity, regardless of size, contains at least two functional internal work centers. These always include a direct labor work center (hands-on equipment service) and an indirect labor work center (management, administration, repair parts, etc.).

(2) A current copy of the Tables of Distribution and Allowances (TDA) must always be on-hand in the maintenance activity. Enter all personnel, direct labor and indirect labor on the monthly time sheet. The numbers for authorized personnel annotated on the monthly time sheet will come from that TDA. **Enter only the number of authorized and on-hand direct labor personnel on the bottom blocks of the monthly time sheet.** The on-hand figures entered on the monthly time sheet will reflect the numbers of direct labor personnel physically present on the last duty day of the report month. Under Time Sheet Information, the Personnel Assigned field should account for all shop personnel, direct and indirect. Use the instructions below when entering data into your monthly timesheet in the DMLSS Maintenance Module.

(3) Regular hours. These are the number man-hours available to each direct labor individual based the number of normal working days in the report month, multiplied by eight (8) hours per day. If the maintenance activity has contractor personnel working full time in the shop, their hours should be counted as regular hours, if not, their hours should be accounted as work by other. Other services personnel or reservists on active duty should have their hours included in the regular hours. Annotate page three of the MMR with information relating to contractor, reserve or other service personnel. For direct labor personnel who were departing or arriving, and were not available for the entire report month, enter only their actual available duty man-hours in the regular hours blocks. For indirect labor personnel, enter zero manhours on the monthly time sheet. If indirect labor personnel (OIC, NCOIC, etc.) do complete some scheduled or unscheduled services, add their actual expended hours, from the completed work orders, in the 'regular hours' blocks. Otherwise, enter zeros in the regular hours block for all indirect labor personnel. Manually annotate information on all arrivals and departures of personnel during the report month in the remarks section on page three of the MMR.

Note: Training holidays called by a commander are duty days and must be included in the regular hours. The training holiday hours are to be captured as non-duty absence. Conversely, a holiday or administrative absence declared by the president (i.e., Christmas Eve, National Day of Mourning, etc.) is not a duty day.

(4) Overtime hours are those direct labor man-hours that exceed 40 hours per week in the performance of the medical equipment maintenance mission and for which **no** compensatory time is given.

(5) Non-duty absence hours are direct labor man-hours not available to the work center. Some categories of non-duty absence are annual leave, sick leave, sick call, time off (but not compensatory time for working overtime), hospitalization, personnel affairs,

absent without leave, leave without pay, and imprisonment. A training holiday called by a commander in the chain of command is a normal duty day that military personnel have off, but civilian personnel must take leave to be absent. Include the training holiday hours in the regular hours and account for the personnel absences as non-duty absence. Note the training holiday information in the remarks section of the MMR.

(6) Duty absence hours are those expended direct labor man-hours performed away from the work center that cannot be captured on work orders. This category includes security briefings, hazardous materiel/hazardous communications training, military training, Basic Noncommissioned Officer Course, and Advance Noncommissioned Officer Course. Also, extra duties such as CQ, duty NCO, or duty officer (performed during normal duty hours), TDY for off-installation technical training at a manufacturer's training site, other off installation TDY, temporary deployment to Global War on Terror (GWOT) operations, PROFIS deployment, and personnel in/out processing are examples of duty absences. **The TDY performed in support of satellite activities is covered in subparagraph (11) below.**

(7) Admin/Support hours are direct labor man-hours lost from the direct labor (hands-on) work center. When a direct labor individual is detailed to act as work order clerk or repair parts clerk, etc., enter the lost direct labor repair man-hours into the data base as admin/support hours. Hours spent entering work order data into the DMLSS data base are admin/support. Hours spent researching equipment for the CEEP/MEDCASE program or performing pre-procurement technical surveys are admin/support. If a direct labor individual is loaned to the MTF headquarters to be the Commander's driver, or is directed by the Logistics Chief to perform other duties outside of the work center, account for these lost direct labor man-hours as admin/support hours. In a small maintenance activity having only direct labor personnel, document all man-hours expended by direct labor individuals to perform administrative and management functions as admin/support hours. Shop clean-up, area police, motor stables; operator vehicle maintenance; and researching information on repair parts not connected with an open work order are other examples of admin/support hours. Explain all admin/support direct labor hours in the MMR remarks section.

(8) Technical training hours are man-hours expended by direct labor personnel that contribute to the maintenance mission but cannot be captured on work orders. Commonly, hours spent attending in-house or on-installation technical training would qualify as technical training. Hours of training provided on-site by a vendor or other outside source would be captured as technical training. Explain technical training in the remarks section of the MMR.

(10) Supervisory hours are man-hours expended only by direct labor personnel performing supervisory functions. Do not enter supervisory manhours expended by indirect labor personnel. Direct labor personnel involvement in supervisory functions should be held to a minimum in maintenance activities with assigned supervisory personnel. An exception might be when a junior NCO is tasked to fill in as NCOIC when the assigned shop NCOIC is absent on leave or pass. Being a team leader is not considered to be a supervisory function.

(11) Travel-time hours are direct labor man-hours expended traveling to and from scheduled and unscheduled maintenance visits. Charge travel-times of 0.3 hour or less to the work in progress. On the MMR, enter as travel-time only travel hours that exceed .3 of an hour one-way. TDY for the purpose of servicing satellite activities will involve travel. For those satellites more distant than 0.3 of an hour of travel time, collect the direct labor man-hours expended to perform the travel to and from the satellites as travel-time. There will be hours of travel to the remote work site, hours of work accumulated on work orders at the work site, and travel back to the home station.

c. Personnel utilization is a measurement of management excellence and indicates how efficiently and effectively the work center's direct labor assets are used. The utilization rate is computed by dividing the charged hours by the hours available for maintenance. The MEDCOM has established an acceptable range for the utilization of personnel between 95 and 100 percent. The maintenance manager will explain utilization percentages above 100 percent or below 95 percent on the MMR.

Note: Hours Available for Work are those hours remaining after Non-Duty Absence and Duty Absence hours are subtracted from Total Hours. Hours Available for Maintenance are those hours remaining after Admin/Support, Technical Training, Supervisory Hours, and Travel Hours are subtracted from Hours Available for Work.

d. The blocks labeled Authenticating Officer should be signed by the Chief, Logistics. The senior maintenance manager present for duty should sign the blocks labeled Maintenance Manager. Your MMR is due at MEDCOM within 5 working days of your end-of-month cycle.

e. The remarks section on page 3 of the MMR is extremely important. The maintenance manager will use it to document unusual entries or changes that appeared on the MMR. Maintenance managers will explain completion rates for scheduled services which fall below the MEDCOM minimum acceptable performance level. Information in the remarks section is of great value when, at a later date, the manager needs to explain or justify data appearing on an MMR. Detailed remarks enhance the usefulness of the MMR to the manager in evaluating the operation of the maintenance activity. If space on the MMR is insufficient, you may attach additional remarks using plain paper.

6-8. MANAGEMENT OF NON-ARMY-OWNED MEDICAL EQUIPMENT

a. Army Medical Department Facilities utilize many items of non-Army owned medical equipment in the care, diagnosis, and treatment of patients; and in performing research. This includes, but is not limited to, medical and laboratory equipment that is leased, rented, loaned, provided on a reagent contract, or identified as cost per test equipment. The management of these categories of medical equipment presents a unique challenge to the medical maintenance manager. Compliance with the Joint Commission, the College of American Pathologists, and other accrediting organizations is a compelling part of that challenge.

b. To ensure compliance with accrediting organizations requirements, regulatory guidance, and other standards, maintenance managers must be involved in all aspects of life cycle management for non-Army owned medical and laboratory equipment used within the activity.

c. Chiefs, Logistics/Directors of Logistics will ensure that:

(1) The maintenance activity is involved in all phases of the acquisition process for non-Army owned medical equipment.

(2) The SOW identifies who is responsible for the repair and/or, performance of scheduled services for the equipment.

(3) The SOW includes the requirement for comprehensive reports from the vendor's representative for the services performed on this equipment.

(4) Regardless of ownership, each item of medical equipment received by an activity is technically inspected by medical maintenance personnel prior to release for use in the diagnosis and/or care of patients or for research use.

(5) Medical and laboratory equipment items that require a documented scheduled service are picked up on the activity's property book and identified as an item requiring maintenance.

(6) The equipment is scheduled for any required services using the authorized automated maintenance management system.

(7) It is MEDCOM policy that all medical equipment, regardless of source, will be included in the maintenance management program. The activity safety committee may approve extended maintenance intervals for selected items of medical equipment after a risk assessment performed by the maintenance manager demonstrates that it is safe to do so.

d. Formulating the program for maintaining non-Army owned medical and laboratory equipment you should keep the following guidelines in mind:

(1) The organization will have a management plan that addresses medical equipment. The process for selecting and acquiring medical equipment is a part of this plan.

(2) The organization maintains documentation of:

(a) A current, accurate, and separate inventory of all equipment in the medical equipment management program, regardless of ownership.

(b) Performance testing and safety testing of all equipment included the management program prior to initial use and periodically thereafter. An equipment testing time frame longer than 12 months may be justified based on previous experience, risk assessment, and safety committee approval.

(c) Performance of scheduled services according to a schedule based on current organizational experience and ongoing monitoring and evaluation.

e. The statement of work for contract/purchase requests for non-government owned medical and laboratory equipment might not list a requirement for the performance of periodic scheduled services. In some instances, the vendor's service representative may state that no periodic scheduled services are required on a specific item of medical equipment because all functions are verified each time that the medical equipment is repaired. For those items of non-government owned equipment, for which no scheduled services are identified, the following procedure should be used by the maintenance manager:

(1) Identify those items of non-government owned medical and laboratory equipment for which no scheduled services have been identified or contracted.

(2) Establish scheduled preventive maintenance, electrical safety testing, and calibration/verification/certification services for the equipment. Establish base dates for these equipment items in the automated maintenance management data base. Use the scheduled services already assigned to like items of equipment as a guide.

f. The maintenance manager will:

(1) Inform the supervisors of the equipment operators that the maintenance activity requires copies of all completed service reports provided by equipment manufacturer/vendor service representatives. Equipment operators and their supervisors should not contact vendors for equipment services unless appointed as Contracting Officer Representatives.

(2) Ensure that upon receipt of a vendor's service report, the completed service is recorded in the automated data base.

(3) Adjust the scheduled services base date forward one-year. If the manufacturer has recommended a different interval for the performance of scheduled services, use the most stringent interval.

(4) Ensure that the DD Form 2163 (Medical Equipment Verification/Certification) is attached or updated to serve as a visual indicator of the date the next service is due. The DD FORM 2163 may be updated by the vendor service representative or by the activity maintenance personnel.

6-9. RADIATION PROTECTION PROGRAM FILES

a. The permanent Radiation Protection Program Files (RPPF) will be established IAW *AR 25-400-2* [The Army Record Information Management System (ARIMS)] using file number 750-8i. The RPPF are mandated by provisions of *21 Code of Federal Regulations* (*CFR*), subchapter J; *TB MED 521*; and *TB MED 750-1*. A separate RPPF will be initiated and maintained for each x-ray unit/system owned by a MEDCOM activity. Six part folders are recommended but not required to hold the RPPF. At a minimum, each RPPF must contain the following documents:

(1) Initial acceptance inspection package (except for dental).

(2) The pink copy of all FDA Forms 2579, or approved automated forms, submitted to the Food and Drug Administration.

(3) The latest DD Form 2164 with attached list of TMDE used to perform Calibration/Verification/Certification.

(4) Copy of the initial radiation survey and most recent radiation survey.

(5) Current copy of the applicable automated maintenance history.

(6) All work orders generated subsequent to the date of the maintenance history.

(7) Copies of all turn-in forms generated when x-ray unit/system disposed of through DRMO.

(8) Copy of work order used condition code x-ray unit/system disposed of through DRMO.

(9) Copy of change of custody document for x-ray unit/system traded in to a manufacturer against the purchase of a new x-ray unit/system.

Note: The Form FDA 2579 must be completed and forwarded to the FDA within 15 days of the installation of x-ray equipment. If the x-ray equipment is installed by contractor personnel, the contractor must furnish you the original of the owner's (pink) copy of the Form FDA 2579 within 15 days (or a paper copy of the electronic form transmitted to FDA). If the x-ray equipment is installed by MTF personnel, the installer must maintain the installer's (blue) copy in his/her personnel file for five years.

b. The individual RPPF may be used as the warranty and/or contract file for each x-ray unit/system. If used as a warranty file, copies of all purchase requests and shipping documents should be in the RPPF if available. If used as the contract file for the x-ray unit/system, a copy of the annual service contract, if applicable, should be in the RPPF. If an x-ray unit/system is serviced by a contractor, copies of all contractor service reports should be placed in the RPPF.

c. The Command Logistics Review Team continues to find deficiencies in the RPPF. The primary problems are missing documents, incomplete documents, and/or outdated documents:

(1) The FDA Forms 2579 incorrectly filled out or missing.

(2) The DD Form 2164 not signed by Medical Equipment Repairer (MER) performing calibration.

(3) Failure to attach list of TMDE to DD Forms 2164.

(4) Calibration date of TMDE listed instead of expiration date of calibration

. (5) Missing initial and latest radiation surveys.

(6) Current radiation surveys not posted to maintenance history using appropriate procedures.

(7) Outdated maintenance histories.

d. Whenever any of the required documents is missing from an RPPF, the Maintenance Manager will make every effort to locate the missing documents. The Maintenance Manager will place an explanatory, signed memorandum in the appropriate RPPF to account for the documents not located. For missing radiation protection surveys, contact the Radiation Protection Officer. If an FDA Form 2579 is missing, contact the vendor who installed the x-ray unit/system. If no FDA Form 2579 can be located, the maintenance manager will initiate a duplicate form in accordance with instructions in TB MED 750-1.

e. If the x-ray unit/system is laterally transferred, the entire RPPF should be sent to the receiving activity. If the x-ray unit/system is sent to DRMO, the RPPF must be retained in the current file area (CFA) for a period of five years. The file folder label of a unit/system turned-in to DRMO should be annotated "Destroy in CFA on... (insert a date that is five years forward from the date of acceptance by DRMO or acceptance by an equipment manufacturer as a trade-in)".

CHAPTER 7. ENVIRONMENTAL SERVICES MANAGEMENT IN HEALTHCARE ORGANIZATIONS

7-1. ENVIRONMENTAL SERVICES MANAGEMENT - SCOPE

a. The scope of Environmental Services (ES) management in the HCA encompasses, at minimum, these core functions:

- Textile care services (laundry and linen distribution),
- Housekeeping services, and
- Regulated medical waste disposition.

(1) The Director/Chief of Logistics will have management responsibility over HCA Environmental Services.

(2) The Chief of Environmental Services (C, ES,) will have functional responsibility and must be a qualified Healthcare Environmental Services Manager (i.e., GS-673 occupational series) assigned to the HCA staff to manage the ES integrated functions.

(3) The C, ES, will be responsible and accountable for the submission of data to the USAMEDCOM Environmental Service Management Information System (ESMIS) using the **http://www.medlogspt.army.mil** website.

(4) The Army Civilian Training, Education, and Development System (ACTEDS) plan for the GS-673 Occupational Series provides the careerist and management with a guide to assist in career enhancement and progression. Training and development planning is essential in developing and enhancing the C, ES's knowledge, skills, and abilities. The ACTEDS, if followed, will provide all ES personnel the avenue to become more proficient in the field.

b. Further guidance, if needed, may be obtained upon request from the USAMEDCOM ES Program Management Office.

7-2. MANAGEMENT OF HEALTHCARE TEXTILE CARE SERVICES

Policy and Procedural Guidance

a. The current editions of following publications will be readily accessible: *AR 40-61*; *AR 210-130*; *29 CFR*; and the Joint Commission (*JC) Accreditation Manual for Healthcare Organizations*.

b. The HCA commander will establish a Linen Management Committee (LMC).

c. The C, ES oversees the day-to-day functions involved with management of textile care Services to include textile accounting, identifying requirements, stockage levels, storage, handling, distribution and contract administration.

d. The C, ES will ensure that:

Textile Services Operations Program:

(1) Complies with the HCA infection control procedures.

(2) Provides for textile repair and special fabrications.

(3) Provides a documented continuing education program for textile services personnel.

Textile Accounting:

(1) HCA-owned-and-provided textiles are accounted for on DA Form 1296 or automated equivalent.

(2) DA Form 2064 or automated equivalent and voucher files are used to support all entries.

(3) Records are held for two years after the last posting date and then destroyed.

Textile Inventories:

(1) Linen inventories are conducted at least annually for HCA-owned and provided textiles, and the results are used to evaluate the effectiveness of the Textile Services Program.

(2) DA Form 444 or automated equivalent is prepared for HCA-owned-and-provided textiles to document inventory gains and losses and to adjust informal accounting records.

(3) Inventory results for HCA-owned-and-provided textiles are reported through the LMC to the Commander for appropriate action and approval.

Textile Stockage Levels:

(1) Economic stock levels are established at the customers' locations.

(2) Customer linen usage is periodically reviewed, and patterns of inappropriate use are corrected.

Textile Handling, Storage and Distribution:

(1) Clean linen is delivered to the user in a manner that minimizes microbial contamination from surface contact or airborne deposition.

(2) Collection and processing of soiled linen is performed in accordance with the OSHA Blood-borne Pathogens standards.

(3) Soiled Linen is transported in closed containers.

Textile Disposal:

(1) Salvageable HCA-owned-and-provided textiles are turned in to the supporting DRMO or converted to rags.

(2) A disinterested officer is appointed on orders to certify that salvageable HCA-owned textiles are converted to rags.

Linen Control:

(1) Policy is established, and enforced by the LMC, to prevent the theft, abuse, and misuse of linen.

(2) HCA-owned linen is marked with HCA logo or by other means to identify it as government property.

(3) Contractor-owned-and-provided textiles are marked as prescribed in the contract.

(4) The HCA has a policy established and approved the commander, for the use of scrubs.

Contract Laundry Services:

(1) The ES Linen Management Officer, is designated as the COR if the linen/laundry service is contracted by the HCA.

(2) A quality assurance surveillance program is implemented to evaluate quality, quantity, and timeliness of performance in accordance with contract specifications.

(3) The recommended practices provided in American National Standard Institute (ANSI) (www.ansi.org) and the Healthcare Laundry Accreditation Council (HLAC) (www.hlacnet.org) are included in contract specifications.

Exposure Control Plan:

(1) The HCA or contractor, as applicable, has an Exposure Control Plan (ECP), in accordance with *29 CFR 1910.1030* and JC requirements.

(2) The ECP identifies tasks and procedures where textile-care- services employees may be at risk of encountering occupational exposure to blood- borne pathogens.

(3) The ECP is reviewed and updated annually, and is available to all HCA textile-care-services employees.

Linen Management Committee:

(1) The HCA has an established LMC to recommend linen management policy and review program performance.

(2) The LMC consists of the following appointed members: Deputy Commander for Administration; Deputy Commander for Clinical Services; Chief, Logistics/Director of Logistics; C, Environmental Services; Chief Nurse; Infection Control Officer, Chief Dept of Emergency Medicine; Others, as required.

(3) LMCs if integrated with another HCA (parent) committee must be sanctioned by the commander and fully performs its responsibilities.

7-3. MANAGEMENT OF HEALTHCARE HOUSEKEEPING SERVICES

Policy and Procedural Guidance

a. The current editions of following publications will be readily accessible: *AR 40-61, AR 210-130; 29 CFR*; and the JC Accreditation Manual for Healthcare Organizations.

b. The C, ES / ES Housekeeping Officer oversees the day-to-day functions involved with management of HCA Housekeeping Services.

c. The ES Housekeeping Officer, will ensure that:

Housekeeping Services Operations:

(1) A written cleaning schedule and cleaning procedures are established.

(2) A training program is in place for housekeeping employees, and documentation is maintained on personnel trained, and the training topic

Chemicals:

(1) The HCA's Infection Control Committee provides written approval, in its meeting minutes, of all chemical products used by the housekeeping organization. Chemical cleaning products must be approved annually or more often as necessary.

(2) The housekeeping organization follows prescribed manufacturer-recommended dilution rates when mixing the disinfectant detergents for prevention of nosocomial infection in patient care areas.

(3) The housekeeping organization follows prescribed contact times when applying the disinfectant detergents.

(4) The Materiel Data Safety Sheets (MSDS) for cleaning supplies are readily accessible. Note: As a minimum, a current and readable MSDS for each product in use should be located in a binder in each housekeeping closet.

(5) The housekeeping organization properly labels all secondary containers whenever cleaning supplies are transferred from the manufacturer's original container.

Infection Control:

(1) The HCA housekeeping services program integrates with the facility's infection control program.

(2) Approval is obtained from the local Infection Control Committee for cleaning procedures and cleaning supplies.

Contracting Housekeeping Services:

The C, ES / ES Housekeeping Officer is designated, in writing, as the COR. he Contracting Officer is responsible for quality assurance surveillance of the contractor's performance.

Quality Assurance Surveillance:

(1) Establish and maintain a quality assurance surveillance plan to assess and measure housekeeping service performance.

(2) The HCA housekeeping officer establishes and properly implements a random sampling inspection system, in accordance with USAMEDCOM guidelines, to evaluate the quality of contract performance.

Exposure Control Plan:

(1) The HCA has a current Blood-borne Pathogens Exposure Control Plan that identifies by position, task, and procedures where housekeeping services employees are at risk of occupational exposure to blood borne pathogens.

(2) The current Blood-borne Pathogens Exposure Control Plan is readily available for review by all housekeeping services employees.

7-4. MANAGEMENT OF REGULATED MEDICAL WASTE (RMW)

Policy and Procedural Guidance

a. In addition to hospital and installation regulations, current editions of the following publications will be readily accessible: *AR 40-61; AR 200-1; AR 200-1, Spill / Emergency Plans/Waste Management Plan*; Applicable State and Local regulations; *USAMEDCOM Regulation 40-35; 29 CFR*; and the *JC Accreditation Manual for Healthcare Organizations*.

b. The C, ES, will have functional responsibility for the collection, storage, and disposal of RMW.

c. The HCA Preventive Medicine Service will assist the C, ES in the management of RMW.

d. RMW Definition: Waste generated in the diagnosis, treatment, or immunization of human beings or animals which is capable of causing disease or which, if not handled properly, poses a risk to individual or a community. These wastes are also called “Infectious Waste,” Biohazardous Waste,” “Clinical Waste,” Biomedical Waste,” or simply “Medical Waste.”

e. The C, ES, will ensure that:

Management of RMW Program:

(1) Government personnel and contractor employees are trained in proper collection and handling of RMW.

(2) Procedures are in effect to (1) validate the treatment and destruction of RMW shipments and (2) insure MTF RMW generation weight closely equates to the contractors invoice weight.

Collection & Handling

(1) Sharps are placed into puncture resistant container designated for sharps use.

(2) RMW is placed in containers only designated for RMW.

(3) RMW is deposited in leak proof, puncture resistant, plastic bag lined receptacles.

(4) Plastic bags are sturdy, tear resistant, 3-mil thick bags of instillation-specific color (generally red).

(5) State requirements regarding the thickness or strength of the RMW bag for waste collection are to be met. Meeting the state requirement takes precedence over the thickness and strength requirements of *MEDCOM Reg 40-35* and *SB 8-75-11*.

(6) Medical waste bags are securely tied and sealed before being removed from the points of generation.

(7) Medical waste bags are not shaken or squeezed in an attempt to reduce volume and never compact or crush the waste to make room for more.

(8) Sealed medical waste bags are carried by their necks to the transport cart and not lifted or held by the bottom or sides.

(9) Sealed medical waste bags are carried away form the body.

(10) Gloves are worn when handling bagged RMW.

(11) Sharps containers are removed from service when approximately three-fourths full.

Storage:

(1) RMW waste is stored in a secure, properly identified area that is kept clean and free of pests.

(2) Main storage area is identified by affixing a sign bearing an OSHA biohazard symbol and words identifying the item being stored (RMW) to the outside of the storage facility.

(3) Pathological wastes are refrigerated or frozen while awaiting pick up for disposal.

(4) Pathological wastes are removed from the refrigerators/freezer and disposed of within 30 days.

Transport:

Within the Activity:

(1) Housekeeping, or other designated personnel, collect and transport RMW to a facility RMW holding area.

(2) Carts used to transport RMW are constructed of readily cleanable material, plastic, or stainless steel.

(3) Carts used to transport RMW within the MTF are cleaned with an Environmental Protection Agency (EPA) registered hospital detergent-disinfectant, either weekly or at a frequency specified by the MTF.

(4) Bags of RMW are placed in leak proof, rigid containers and marked with the universal biohazard symbol. Red bags do no need to be marked with the universal biohazard symbol unless required by state of local regulations.

On the Installation:

(1) RMW destined for disposal is transported in a government owned or contractor-owned vehicle. The use of privately owned vehicles is prohibited.

(2) A spill containment and clean-up kit is maintained in each vehicle transporting RMW.

Outside the Installation Boundaries:

(1) Commercial activities contracted to transport are registered, licensed, and permitted RMW Transporters in accordance with all federal, state, and local laws and regulations.

(2) Government organizations that transport RMW follow the guidance provided in *MEDCOM Reg 40-35*.

(3) Only a DoD certifying official sign shipping papers. A DoD certifying official is a person who has successfully completed an approved DoD hazardous materials certification course and is appointed in writing by activity/unit commander.

Treatment/Disposal:

(1) Commercial activities contracted to treat and dispose of RMW are licensed to accept and process RMW in accordance with federal, state, and local requirements.

(2) On Installation treatment of RMW follow procedures and guidance provided in *MEDCOM Reg 40-35*.

Documentation:

(1) RMW generation-weights are tracked by the activity.

(2) RMW weight reports are maintained on file for two (2) years.

(3) Tracking documents (manifests) are maintained for the number of years required by the state.

Contingency Planning:

(1) The activity maintains a detailed contingency plan for RMW disposal as a means of managing medical waste when primary means of disposal are limited or prohibited.

(2) Contingency plans are reviewed and updated annually.

(3) Contingency plans meet all local, state, and federal regulations.

f. The Preventive Medicine Service will:

(1) Assist in developing local RMW management policies and guidance.

(2) Monitor the management of RMW, including collection, storage, treatment and disposal.

(3) Provide technical advice in identifying and characterizing RMW.

(4) Participate in the planning and providing of training.

CHAPTER 8. FACILITY LIFE-CYCLE MANAGEMENT

8-1. PURPOSE

This chapter of the *SB 8-75-11* prescribes OTSG/USAMEDCOM requirements for managing facilities at the medical treatment center or activity level.

8-2. SCOPE

This chapter describes the roles and responsibilities of the facility manager at the installation level. It describes the functions associated with operating, maintaining, repairing, and constructing USAMEDCOM facilities. It is developed as a life cycle (cradle-to-grave) standard for facility management.

a. Facility Life Cycle Management (FLCM). FLCM is the process of economically managing facility operations, maintenance, repair, and alterations from the time a facility is constructed until it is demolished, in order to maximize productive use of the facility and realize a positive economic return on investment. The execution of FLCM requires that all statutory and headquarters-based financial thresholds be adhered to. Thresholds annotated in this document can change so it is incumbent upon the facility manager to verify the threshold before proceeding with any repair or construction activity.

b. Investment Strategy. A sound investment and management strategy is essential in the effective allocation of limited financial and personnel resources, and the successful implementation of a facility management program. In order to gauge the success of the program and ultimately the mission of USAMEDCOM as a world-class health care organization, components of the program must be evaluated against performance indicators that reflect the best in private and governmental health care facility management. This document is the basis for a facility management performance plan.

8-3. APPLICABILITY

This document applies to all MEDCENS, MEDDACs, Health Clinics, and all facility management activities within USAMEDCOM MSCs. These include RMCs, AMEDD Center and School, US. Army Center for Health Promotion and Preventive Medicine (USACHPPM), US. Army Dental Command (DENCOM), US. Army Medical Research and Materiel Command (MRMC), the US. Army Veterinary Command (VETCOM), and the Armed Forces Institute of Pathology. It is not limited to only those facilities managed through the Office of the Assistant Secretary of Defense for Health Affairs (ASD/HA) Defense Health Program.

8-4. FACILITIES STRATEGY, VISION, MISSION, OBJECTIVES

a. Facilities Strategy. USAMEDCOM facilities strategy is to:

(1) Acquire, locate, size and configure facilities to meet the USAMEDCOM mission and patient demands.

(2) Acquire and maintain facilities that provide a quality environment of care. The facilities strategy focuses on sustainment and modernization of facilities, available funding on the right projects, integration and prioritization of maintenance and repair, military construction resources, and establishment of a clear and stable facility investment environment. Key elements of the Facility Strategy include the assessment of existing facilities, the projection of mission and workload demands, and the needs of local commanders. The assessment of USAMEDCOM facilities is based on a consistent application of the Facility Condition Index (FCI). The projection of mission and workload demands is based upon workload analysis and/or the health care requirements analysis of patient demand.

b. Vision. The vision of the USAMEDCOM facilities is one of having safe and reliable facilities available when and where needed with capabilities necessary to effectively support OTSG/USAMEDCOM missions.

c. Mission. The mission of the USAMEDCOM facilities program is to provide, operate and maintain in a cost-effective manner the facilities necessary to support OTSG/USAMEDCOM – in both war and peace.

d. Supporting Objectives

(1) Required Capabilities. Facilities are structured to provide the right capabilities. Capabilities address such issues as ensuring that facilities are correctly sized to meet the mission and workload demands. The overall inventory of USAMEDCOM facilities will be monitored to insure that it is composed of the correct type of facilities and in the correct numbers to meet mission demands. The facilities will be configured to support the mission (specialty vs. primary care clinics, outpatient facilities vs. inpatient, and appropriate type of laboratory facility). The facilities will be located where they are needed and can best serve the beneficiary population.

(2) Required Conditions. Facilities are maintained and operated to provide the right conditions. Conditions address the state of the facilities that exist. Facilities will be in compliance with regulatory standards (Joint Commission, American Association for Accreditation of Laboratory Animal Care (AAALAC, etc.), and be safe and reliable. Facilities will also provide quality working conditions for USAMEDCOM personnel. Facilities management staffs will take actions to assure that the property assets are protected from deterioration, thus providing USAMEDCOM personnel with platforms for effective and efficient operations.

(3) Appropriate Level of Resources. Resources address the funding necessary to acquire, sustain, restore, and modernize both the facilities and the support elements necessary to manage and safely operate USAMEDCOM's facilities.

(4) Information Management and Information Technology Systems IM/ITS Capabilities. IM/ITS are leveraged to support facility operations. Information addresses the data necessary for management of the facilities, reporting the progress of the strategic plan, the condition of the inventory and the justification for resources.

8-5. FACILITY LIFE-CYCLE INVESTMENT PROGRAM ELEMENTS

a. General. The facility investment program is defined in accordance with current Department of Defense program elements of Sustainment, Restoration, and Modernization (SRM), and includes medical military construction.

b. SRM. The SRM program elements must be prioritized to ensure maximum effective use of available resources. They are prioritized as follows:

(1) Sustainment. Refer to the *DoD Unit Cost Factor Handbook* for a complete definition of sustainment. In part, sustainment is the process of planning, programming, and executing those programs necessary to maintain the infrastructure of a facility from the time it is constructed until retirement. Within this context, sustainment can be viewed as a cyclic process from which financial and personnel resources are used to provide reliable systems and an aesthetically sound, safe, and functional environment. Sustainment involves the cycle of on-going routine repair and maintenance and also encompasses scheduled major repairs of the facility, including:

(a) Scheduled and Unscheduled Maintenance. Scheduled maintenance (often termed preventive maintenance) is given the highest funding priority, since it significantly improves reliability of systems and components. Preventive maintenance is the baseline for supporting continuity of healthcare operations. Unscheduled maintenance is sometimes referred to as demand maintenance or corrective maintenance.

(b) Scheduled Major Repairs. The next priority is given to scheduled major repair. Deterioration, caused by many factors including operational usage and environmental conditions, will eventually diminish system performance below a required level. Equipment and major systems must be repaired by major overhaul or replaced.

(2) Restoration. Restoration includes repair and replacement work to restore damaged facilities due to accident or failure attributable to inadequate sustainment, excessive age, or other causes. (Refer to the *DoD Unit Cost Factor handbook* for a complete definition of restoration.) This element holds a priority level below sustainment provided sustainment is being performed. Facilities that are not maintained experience accelerated deterioration. In addition to lack of maintenance, manufacturer's flaws, poor installation, and adverse environmental conditions can cause equipment breakdown before normal life expectancy. A standardized facility assessment is required to manage restoration.

(3) Modernization. Modernization includes alteration of facilities to implement a new, higher standard (including regulatory changes), to accommodate new functions, or to replace building components that typically last more than 50 years (such as foundations and structural components). (Refer to the *DoD Unit Cost Factor Handbook* for a complete definition of modernization.) Requirements for modernization of healthcare and research facilities have changed significantly as population demographics have shifted and the mission of the Army Medical Department has changed. Funds for modernization can be operations and maintenance-based or military construction-based depending on the statutory requirements imposed on these programs. Under any funding scenario, modernization is a capital investment that is managed as a long-term requirement. A master plan is required to support modernization.

c. Capital Investments

(1) Service Life. For use at the programmatic level, the life expectancy of healthcare facilities has been established at an average service life. Referencing the 2001 publication by Whitestone Research, *Building Maintenance and Repair Costs*, repairs for major components are required in typical hospitals between 20 to 30 years (average 25 years). Integrating projects consisting of both major repairs and modernization during this period can be a very effective cost avoidance technique. Proper planning and requirements integration is necessary to integrate upgrades to the infrastructure with space changes required for modernization.

(2) Plant Replacement Value (PRV). The investment strategy can be easily condensed and restated in terms of PRV. PRV provides a means of recognizing widely varying facility conditions with the goal of an annually adjusted process that calculates rate of investment over a period of time. PRV can be adjusted to account for size of facility, relative location, makeup and complexity of infrastructure, contingencies for support facilities, fixed equipment, engineering and architectural cost, and economic conditions, such as inflation. It represents the sum of costs, by facility type and location, to replace the inventory in kind. The PRV is also adjusted as facilities close or new facilities come online. The method used in the calculation of PRV is:

PRV = Facility Quantity x Cost Factor x Area Cost Factor x 1.2

Facility quantity (gross square feet for buildings) is based on building inventory recorded in IFS at the installation. Construction cost factors are listed in the latest version of the *DoD Facilities Cost Factors Handbook*. Area cost factors, published annually by the Tri-service Committee on Cost Engineering, are a geographic location adjustment factor for costs of labor, material, and equipment. The 1.2 multiplier accounts for supervision, inspection, overhead, and design associated with new construction.

d. Master Planning.

(1) General. Master plans should be updated every five years. The purpose of the Master Plan is to assess the condition and capabilities of health, dental, veterinary and medical research laboratory facilities, identify current and future facility needs, and recommend strategies for facility development needed to accommodate anticipated growth and/or change in the facility and/or its mission. The Master Plan will provide a guideline to assist in identifying proactive solutions to changing mission requirements, and allows senior leadership an orderly transition plan from current facilities to a future health care delivery environment based on predicted resource needs. This insures that future changes or renovation projects are not only considered individually, but for how they affect the facility as a whole, and enables the organization to match missions with facility capabilities. In addition, a department-level facility Master Plan, developed in accordance with the specific medical/dental activity Business Plan, the Multi Service Market, RMC and TriCare Regional Office (TRO) Business Plans, is required to guide the Facility Manager and the Health Facility Planning Agency (HFPA) so that needed facility repairs, upgrades, modifications, restoration, modernization or replacement projects are planned and executed based upon a comprehensive Master Plan. Properly planned, phased, funded, and prioritized, projects supporting the business plan and Master Plan, will provide cost effective and efficient facility solutions to the USAMEDCOM Facility Life Cycle Management program.

(2) Description. The effort contained in the scope of work will provide the subject facility and USAMEDCOM/HFPA with a Master Plan for department-level space planning correlated with health care analysis and planning. The end result will include a list of prioritized project technical solutions to identified facility and operational space deficiencies with a phased plan of correction, and other required deliverables. These solutions and corresponding quantifiable support will follow the methodology listed below to ensure compatibility with other USAMEDCOM/HFPA master planning products. The Master Planning Scope of Work will outline the process and products required for the Master Planning effort and outlines details, timelines, delivery schedule, required analysis or services and any deliverables associated with those tasks. Requirements for the Scope of Work are detailed below.

(3) Process

(a) Project Initiation. A master plan update should be scheduled and requested by the effected MTF, either in accordance with a proposed recurring plan, or in response to, or anticipation of, a significant operational impact. Central funding is sometimes available from MEDCOM, but Master Plans can also be resourced at lower levels. Once a requirement for a master plan is identified, scheduling and funding should be coordinated with MEDCOM and HFPA, which will manage and perform the master planning activities. Once a scope is defined, and support activities are in place, a kick off meeting will be scheduled, including a briefing to the Commander on project goals, assumptions, process and schedule. MTF, regional and local network management will be contacted to obtain, evaluate and validate site specific data such as facility assessments, Statements of Condition, business plans, raw data (population workload, staffing) and other information deemed necessary. Specific site visits will be coordinated directly with HFPA and the local leadership. HFPA will normally attend all site visits and a mutually agreed upon calendar will be coordinated in advance. A number of site visits will be required to develop the identified site-specific deliverables. The following will be the typical number of general tasks and site visits:

Data collection.

25%: Project Kickoff Meeting and Health Planning Review.

50%: Staffing, Program for Design (PFD), scenarios and concept design options.

90%: Final Planning review with test & fit options and draft phasing approach.

(b) Health Care/Business Analysis. Retrospective and prospective data analysis to identify trends. Different alternatives will be developed based on alternative futures identified by the organization.

(c) Data Collection. Workload, staffing, and customer base information will be collected and analyzed to help validate any previous business planning efforts. This includes, but is not limited to, validation of the mission statement, business plans, beneficiary population data (MCFAS, user MCFAS and user CHCS), workload data (MEPRS/CHCS), and staffing (TDA or contracted staff).

(d) Demand Analysis. A demand analysis will be developed based on population served, enrollment (into TRICARE Health, TRICARE Dental Plan, and other enrollment programs). Based on this analysis, utilization trends will be projected.

(e) Planning Scenarios. Based upon this data, provider and staffing requirements, volume thresholds/optimization, and functional alignment options will be established. These options will be based on the various futures identified by the organization.

(f) Space Requirements Forecast. Based on the scenarios and requirements listed above, contractor will develop PFDs. These PFDs will demonstrate the space required to meet the planning scenarios and demand analysis.

(4) Site/Facility Analysis:

(a) Data Collection – Facilities. All existing space utilization plans, architectural Computer-Aided Drafting and Design (CADD) or hard copy drawings, site drawings, list of current projects and any facility assessments or deficiency tabulations will be collected. This information will be integrated into the facility planning scenarios

(b) Facility Planning Scenarios. Based on the Health Care/Business Operations Analysis and the Site/Facility Analysis, a functional facility analysis will be conducted resulting in alternative architectural solutions. Facility planning will be summarized in both narrative and graphic representations.

(c) Existing conditions. The current space utilization and departmental boundaries of the existing structures will be documented in existing condition Computer-Aided Design/Drawing (CAD).

(d) Master plan concept. Departmental function alignment options (big-block design) will be developed in narrative and CAD format and will be based on the projected PFD and future health care scenarios. These drawings will be submitted in the interim and final deliverables, but will also be used as a tool to facilitate alternative development with the MTF leadership.

(e) Plans of correction. Final master plan concept and test-fit design will be developed as the culmination of health care analysis, site/facility assessment and facility planning. The plans of correction will be a comprehensive use/reuse plan for the organization's total infrastructure requirement (all buildings identified in the project specific requirements). The plan will account for facility opportunities and constraints and solutions will comply with all applicable standards and health care codes to include the following: life safety; ADA (Americans with Disabilities Act); Joint Commission; NFPA; OSHA; AAALAC; Council of American Pathologists (CAP); and American Institute of Architects (AIA). Test-fit design will be developed for specific projects that are identified as the organization's priority. These projects will be categorized based on the Levels of Facility Alteration outlined in *MIL-HDBK-1191*, Section 1, General Guidance. The purpose of the test-fit design includes the following: graphic presentation of how specific functions fit into identified space; precursor to full design or work plan development; and to provide detailed information for cost estimate development.

(f) Implementation Plan and Cost Estimates. Based on the agreed upon alternatives, a sequenced phasing of projects will be developed based on funding opportunities and constraints. The implementation plan will detail how an organization can execute the moves, upgrade, renovation and/or replacement objectives outlined in the plans of correction. Phases are intended to reflect functional, engineering and transitional requirements. Project descriptions will contain general scope and cost estimates will be sensitive to the integrated engineering and architectural findings but will also consider different funding options (i.e. Operations & Maintenance (O&M) funds, Host Nation, MILCON and alternative timelines particular to the military.

(5) Final Reports. Results of all analysis, planning, recommendations, and discussion with regard to the specified deliverables will be documented in a final report, including a separate executive summary. The narrative will be directly keyed to supporting graphics and photography, including supporting digital photographs and graphics (CD-ROMs with CADD drawings).

There shall be one combined final report and executive summary for each of the following. Copies of the Reports will be called out in the Project Specific Scope and provided to the following:

- Subject Facility/Organization
- RMC (if subject facility/ organization are a sub-unit of an RMC).
- US. Army Health Facility Planning Agency, Falls Church, VA.
- US. Army USAMEDCOM, Assistant Chief of Staff for Installations, Environment and Facility Management (ACSIE&FM), Fort Sam Houston, San Antonio, Texas

8-6. ORGANIZATIONAL ALIGNMENT

a. General. The organizations primarily involved in the administration of facility life-cycle management within the US. Army Medical Command are:

(1) Facility management component and/or logistics division at the activity level;
(2) Facility Director and/or logistics division at the RMC/MSC;
(3) US. Army Health Facility Planning Agency (HFPA); and
(4) Office of the ACSIE&FM at USAMEDCOM Headquarters.

b. ACSIE&FM. The ACSIE&FM is the principal staff officer to the USAMEDCOM Commanding General and the Army Surgeon General. ACSIE&FM is the proponent for USAMEDCOM installation management. ACSIE&FM interfaces with Army planners, obtains and distributes resources, conveys facility program guidance, policies and priorities, assesses and evaluates facility programs, and takes action to optimize facility investments.

c. US. Army Health Facility Planning Agency (HFPA). HFPA directly supports ACSIE&FM and RMC/MSC in planning, healthcare construction standards and technology, design and construction facilitation, and project integration of large capital investment projects. HFPA administers the Medical Military Construction program. HFPA is also the designated User Representative for the Office of the Surgeon General, per *AR 415-15*.

d. Regional Medical Commands/Major Subordinate Commands. RMCs/MSCs are both tactical and operational in mission. Tactical functions have a planning horizon of one to two years. RMCs/MSCs are focused on integration of health care and facility planning and compliance with USAMEDCOM policies and procedures. RMC/MSC facility directors have functions delegated to them by ACSIE&FM. RMC/MSC facility management functions cover the following areas:

(1) Facility assessment and oversight
(2) Major Repair and Restoration, Modernization program
(3) Medical Military Construction Program
(4) Technical assistance
(5) Facility management program execution

e. Facility Management Staffing and Organization:

(1) General. Each MTF, MEDCEN, and research facility shall establish and staff a facility management section proportional to their respective facility. It is required that the section be either a branch established in the logistics division under the C, Logistics, or organized as a Division under Deputy Chief of Administration.

(2) Facility Management Branch. The Facility Management Branch (FMB) performs functions associated with operating, maintaining, and repairing medical and research facilities. In addition to these core functions, a FMB may also perform a wide range of additional responsibilities to include administration of housekeeping, safety, physical security, transportation, medical equipment programs, etc. This document will not address the staffing or organizational requirements for these additional responsibilities. The organizational elements of a facility management branch can be divided into the following:

(a) Management/Administrative
(b) Engineering/Technical Support
(c) Operations and Maintenance (O&M)

(d) Contract Administration/Quality Assurance

(3) Management and Administrative Functions. The management/ administrative element coordinate the planning, organizing, staffing, directing, and control of all facilities support. This element consists of a Chief, Facility Management Branch, and a clerk/typist. Functions for this activity include:

(a) Coordination of planning, organizing, staffing, directing, and controlling facility activities

(b) Serving on key committees and boards

(c) Administrative approval of projects and programs

(d) Oversight of financial programs and budgets

(e) Insuring that facilities meet all applicable requirements for accreditation

(f) Establishing and maintaining liaison with the US. Army Installation Director of Public Works (DPW)

(g) Personnel administration and training

(4) Engineering and Technical Support. The engineering/technical support element provides design and engineering services, programming of major construction, space utilization/space management, and technical support. This element usually consists of an engineer, preferably with electrical or mechanical background, and an engineering technician. The Chief, FMB, may assume the responsibilities of this organizational element. Functions for this activity include:

(a) Manage, track, and monitor engineering work requests, execution, closeout, and warranty issues

(b) Energy management and conservation, and monitoring and control systems

(c) Implementation of Automated Data Processing support systems for maintenance, financial, and project management

(d) Consulting engineering studies and services

(e) Facility master planning

(f) Planning and estimating work

(g) Management of all major repairs: A portion of sustainment and restoration and modernization projects

(h) Space utilization/space management

(i) Project scope development and design

(j) Coordination on the design and execution of Military Construction, Army (MCA) projects

(k) Management of facility as-built plans

(5) Operations and Maintenance Function. The operations and maintenance support element manages maintenance and repair to buildings and structures, and supply and storage of tools and spare parts. This administrative portion of this element typically consists of an engineer with experience in facility maintenance, and an engineering support clerk who is responsible for maintaining job order logs, data entry into DMLSS-FM, maintenance of a facility library, and general clerk/typist. The wage-grade element varies widely depending on whether maintenance is performed in-house or under contract. As a minimum, it is recommended that a small team of maintenance workers be assigned directly to the FMB to handle minor maintenance and repairs. Functions for this activity include:

(a) Operation and maintenance of utility plants and systems

(b) Storage and maintenance of spare parts, materials, and supplies

(c) Maintain an up-to-date equipment inventory

(d) Coordination of work planning and programming activities

(e) Cyclical inspections to systematically identify maintenance and repair requirements

(f) Maintain all critical system records, test reports, and emergency procedure plans

(g) Develop and maintain a maintenance program

(h) Coordinate maintenance-training activities

(i) Maintain a library of (or insure access to) all applicable regulations, codes, and standards as needed to comply with applicable sections of this document.

(6) Contract Administration Function. The contract administration/quality assurance element manages contract activities associated with facilities maintenance and engineering, financial planning, programming, budgeting, execution, accounting, and review. This element typically consists of a contract specialist or resource management analyst, and a facility Quality Assurance Evaluator who is usually an engineering technician with experience in facility maintenance. The Chief, FMB, may assume the contractual and financial duties. Functions for this activity include:

(a) Management of applicable sections of Inter-Service Support Agreements (ISSA) and Memorandum of Agreement (MOA) with support agencies, such as DPW.

(b) Financial oversight of reimbursable accounts.

(c) Administration of contracts within delegated authorities, including conduct of quality assurance, surveillance/evaluation of contractor performance.

(d) Prepare reports required by higher headquarters.

(7) Job Qualifications and Descriptions. Facility Manager qualifications should be one of the following:

(a) Be a registered professional engineer or licensed architect with experience in facility engineering and maintenance in healthcare or research facilities, as applicable. Strong electrical or mechanical background is preferred. The FM must have an in-depth knowledge of and basic experience in facility engineering and maintenance with emphasis on the unique nature and requirements of complex healthcare and research institutions. The FM must possess strong managerial and personnel skills.

(b) Have an advanced degree in business management with experience in facility engineering and maintenance in healthcare or research facilities, as applicable. The FM must have an in-depth knowledge of and basic experience in facility engineering and maintenance with emphasis on the unique nature and requirements of complex healthcare and research institutions. The FM must possess strong managerial and personnel skills.

(c) Have equivalent experience with at least two years experience in facility engineering and maintenance in healthcare or research facilities, as applicable. The FM must possess strong managerial and personnel skills.

(8) Staffing Guidelines.

(a) Actual staffing requirements fluctuate based on the needs of the facility, and depend largely on the extent that maintenance is outsourced or contracted out. USAMEDCOM Logistics ACSLOG is implementing a template that will be used by the manpower community to identify requirements. However, the following data listed below will generate the necessary detail to further strengthen any requirements that are not identified in the template.

(b) Staffing requirements for O&M type work can be accurately based on calculations related to Preventive Maintenance (PM) effort. The number of support personnel (non-O&M) is often based on the number of O&M personnel. Staffing for trade supervisors are based on the total number of tradesman that are required. Once staffing requirements have been determined, they can be benchmarked against industry wide standards. See applicable sections of this document.

(c) To determine staffing requirements, an availability factor must be derived. The availability factor is used to determine the actual man-hours that can be applied to O&M work once training, sick leave, vacation time, holidays, and discretionary time is accounted for.

(d) Non-O&M staffing requirements can be based on roughly 15% of total PM requirements. Staffing organizational arrangements will vary widely depending on the specific needs of the activity.

8-7. FACILITY OPERATIONS AND MAINTENANCE ACTIVITIES

a. General. Operations and maintenance is the cycle of on-going, routine repair, alteration, maintenance and operation of the facility. Operating and maintaining health care and research facilities and associated common use areas is the responsibility of the facility manager.

b. Reliability Centered Maintenance. Reliability Centered Maintenance (RCM) is the integration of reactive maintenance (run-to-failure or breakdown maintenance), and proactive maintenance, such as preventive (interval based) maintenance and Predictive Testing and Inspection (PT&I), also known as predictive maintenance or condition based maintenance. RCM applies these three techniques in combination where each is most appropriate based upon the consequences of equipment failure and its impact upon organization mission, safety, environment, and Life Cycle Cost. This combination produces the required reliability at the minimum maintenance cost. RCM requires that maintenance decisions be based on maintenance requirements supported by sound technical and economic justification.

c. Preventive Maintenance (PM). PM consists of regularly scheduled inspection, adjustments, cleaning, lubrication, parts replacement, calibration, and repair of components and equipment. PM is also referred to as time-driven or interval-based maintenance. PM schedules periodic inspection and maintenance at pre-defined intervals (time, operating hours, or cycles) in an attempt to reduce equipment failures for susceptible equipment. It assumes that these variables can be determined statistically, and therefore one can replace a part due for failure before it fails. The availability of statistical failure information tends to lead to fixed schedules for the overhaul of equipment or the replacement of parts subject to wear. PM is based on the assumption that the overhaul of machinery by disassembly and replacement of worn parts restores the machine to a like-new condition with no harmful effects.

(1) A routine maintenance plan is required on all major and critical equipment, major systems, and components. The plan shall provide procedures with detailed maintenance tasks and associated frequencies. It shall also include a master schedule indicating when maintenance tasks should be performed, so that work is spread evenly throughout the year.

(2) Detailed PM procedures should include the time standard for each procedure (O&M manuals, manufacturer's data, etc.), assignment of crafts or shops to each PM procedure, assignment of tools and materials to each PM procedure, and special notes and warnings.

d. Predictive Testing and Inspection (PT&I), also known as predictive maintenance or condition monitoring, uses primarily non-intrusive testing techniques, visual inspection, and performance data to assess machinery condition. It can complement maintenance tasks with maintenance that is scheduled only when warranted by equipment condition. Continuing analysis of equipment condition-monitoring data allows planning and scheduling of maintenance or repairs in advance of catastrophic and functional failure. The PT&I data collected is used in one of following ways to determine the condition of the equipment and identify the precursors of failure. PT&I does not lend itself to all types of equipment or possible failure modes and therefore should not be the sole type of maintenance practiced. The methods of analysis include:

(a) Trend analysis
(b) Pattern recognition
(c) Data comparison
(d) Tests against limits and ranges
(e) Correlation of multiple technologies
(f) Statistical process analysis

e. Records and Documentation. The facility manager shall be responsible for maintaining the following maintenance records and documentation. This does not preclude any additional documentation required for regulatory compliance or higher headquarters requirements.

(1) Utility connection/Cutoff plans: Provide site and floor plans that indicate the main interior and exterior connection and cutoff points of all utilities. Plans shall contain enough information to enable someone unfamiliar with the facility to locate the connection/cutoff points. The plans shall indicate the room number, panel number, circuit breaker, valve number, etc., of each connection/cutoff point; as well as which system, portion of system, or area that connection/cutoff point controls. These plans are physically distinct from site and floor plans discussed above.

(2) Warranty information: List each piece of equipment furnished by the construction contract and provide a cross reference to the written warranties. The equipment list shall indicate the duration of the warranty, start and end date of warranty, and point of contact for fulfillment of the warranty. Also list all maintenance required by the government to keep the warranty valid.

(3) Equipment inventory: Provide major and critical equipment, major systems, and component inventory in hierarchical format.

(4) Training requirements: Provide a list of recommended training related to operation and maintenance of each installed system including training which is available from the manufacturer or other source.

(5) As-Built Drawing List: Provide a list of up-to-date as-built drawings. Include drawing number and title, and indicate where the drawings and specifications are physically located.

(6) System description: Provide a detailed description of system composition and operation. Descriptive matter and theory shall include technical details that are essential for understanding the system.

(7) Start-up and shutdown procedures: Provide step-by-step instructions to bring systems from static to operational status and from operating to shutdown status.

(8) Normal operating instructions: Provide discussion of the normal operation and control of the system. Include operating norms, i.e., temperatures, pressures, and flow rates expected to each zone and phase of the system. The information shall be supplemented with control/wiring diagrams and data.

(9) System flow diagrams: Provide flow diagrams indicating system liquid, air or gas flow during normal operations.

(10) Emergency operating procedures: Provide emergency procedures for equipment malfunctions and shutdown instructions for fire, explosion, spills, or any other contingency.

(11) Environmental considerations: Provide a listing of systems/equipment which requires special environmental consideration, reporting, testing, analysis, or inspection to comply with Federal and related state/local environmental laws. Examples are backflow-preventer inspections, underground storage tank testing, etc.

(12) Safety instructions: Provide a list of all personnel hazards and equipment safety precautions including recommended safeguards.

(13) Provide a list of all major valves associated the system including valve type, number, function, and location.

f. IM/IT Systems

(1) Computer Aided Design (CAD). It is required that CAD systems, or other automated techniques, be employed to maintain as-built drawings, and other records and documentation.

(2) Computerized Maintenance Management Systems. It is the objective of USAMEDCOM to employ DMLSS-FM in all facilities. Typically, the Computerized Maintenance Management Systems (CMMS) provides for storage and tracking of work orders, routine maintenance, labor information, inventory, and equipment information. This section provides guidelines to assist facility managers in determining the division of work between in-house personnel and contractors. Implementation of DMLSS-FM at a medical or research facility will result in a number of benefits which include reduced equipment downtime, better organization and access of information for accreditation inspections, such as Joint Commission, CAP, and

AAALAC, improved inventory management, increased labor efficiency, identification of chronic equipment malfunctions, centralized maintenance data, extended equipment life, and reduced maintenance costs.

(a) Requirements of DMLSS-FM can be subdivided into those necessary to support accreditation inspections, those required specifically at Army facilities, and those related to data reliability, security, user interface, and information transfer and exchange.

(b) Proper organization of utility systems data and reporting methodology are essential in supporting documentation for accreditation. Below is a list of reports that DMLSS-FM should include to meet this need:

- Report listing all components and characteristics of utility systems.
- Report detailing all work orders performed on critical systems, such as the emergency power system.
- Work order summary report that includes description of problems, responses and associated response dates, and the name of the individual responding.
- Report demonstrating trends of equipment failures, and how these failures are addressed.
- Report summarizing the total work order history for the preventive maintenance program.

(c) Successful implementation of DMLSS-FM is to a large extent determined by the following factors:

- Accurate and up-to-date data collection on equipment, spare parts/materials, vendors, contractors, and personnel.
- On-site training of users and managers. A minimum of 24 hours of input training and 16 hours of output training should be provided.
- System commissioning under operating conditions by creating sample work orders, printing sample reports, etc. The software vendor should provide at least 40 hours of system commissioning.

(3) Nurse Call Systems. Many hospitals need to update or replace their antiquated systems. The ACSIE&FM and the Deputy Chief of Staff for Logistics have entered into a joint venture focusing on updating this critical communication system. Facility Managers and Chiefs, Property Management Branches should determine if their system needs updating or replacing. Such factors as reliability, maintainability, and technical obsolescence, should be considered. The nursing staff is a vital source of information on how the system meets their needs. Departments of Nursing may volunteer to assign a nurse project officer to evaluate the existing system and to recommend upgrades or replacements.

(a) Nurse Call System Classification. Nurse call systems are personal property (fixed). See *AR 735-5*. The nurse call system is not considered as installed building equipment (*DA Pam 420-11*).

(b) Funding. Nurse call systems must be purchased using Other Procurement Defense (OPD) funding under the MEDCASE program. Minor construction or repair funding cannot be used to purchase new, replace, or upgrade nurse call systems. The MEDCASE program pays for all equipment and installation costs. The ACSIE&FM site preparation program pays for site preparation and utility rough-in requirement.

g. Maintenance Contracts. Maintenance contracts are essential elements of a well-rounded facility management program. In most cases, the complexity of modern building equipment makes it unfeasible for maintenance personnel to handle all aspects of building maintenance. Many types of equipment require maintenance to be performed by specially trained personnel. Maintenance contracts can be administered as individual service contracts, comprehensive facility wide contracts, post wide contracts, and regional wide contracts. Typically, facility, post and regional wide maintenance contracts include routine and unscheduled maintenance, with provisions for repairs, and minor construction.

(1) Contract Type: It is the responsibility of the FM to support and provide input into an analysis to determine the most cost effective type of contract to be used. Ultimately, the cost of the contract must be within the funding level provided by higher headquarters.

(2) Major Repairs/Minor Construction (MR/MC): Provisions for minor construction and major repairs can be included as part of a facility maintenance contract. The level of participation by the maintenance contractor in MR/MC should be evaluated in terms of the capability of the FM to perform MR/MC through Job Order Contracting, DPW, and other locally available contract acquisition sources.

(3) Division of Work: Maintenance work is divided into levels depending on the response time and work priority. Work that is not classified as routine preventive maintenance is considered demand maintenance. Each work order is assigned a priority to distinguish the most urgent response requirements from those that require less immediate response. The work order priorities are assigned on the basis of a particular piece of equipment. Each major and critical equipment item, and major system, or major system components will have a response priority assigned to it. The priority categories are as follows:

(a) Priority 1, EMERGENCY: This is work that is required to correct an emergency condition detrimental to the facility mission or that endangers the health and welfare of the staff and patient and reduces the operational effectiveness. Corrective action for emergency work should start immediately and continue until completed.

(b) Priority 2, URGENT: This is work to correct an unsafe condition that is not an immediate hazard to personnel, but must be initiated within the shift and completed within 5 working days.

(c) Priority 3, ROUTINE: This is work to improve the operation of the facility that can be completed within 30 working days.

(d) Priority 4, SCHEDULED: This is work that is not one of the above and can be accomplished within 120 days.

h. Utility Management

(1) Central Plant Operation. Utility management is the management of utilities (electrical, water, natural gas, etc.) necessary to maintain continuous operation of equipment and systems in a facility. It is the responsibility of the facility manager to ensure the operation, maintenance, repair, and improvement of utility plants and systems, including water supply, electrical, heating and ventilation, refrigeration, fuel dispensing, and air conditioning systems is performed in accordance with applicable regulatory and policy guidance.

(2) Operator Training. It is the responsibility of the facility manager to maintain a current list of required operator training.

(3) Permits. The facility manager shall be responsible for maintaining a consolidated list of operator permits in accordance with current statutory and regulatory requirements.

(4) Plant Management Systems. It is the responsibility of the facility manager to operate and maintain plant management systems in an efficient and cost effective manner.

i. Energy Management

(1) General. It is the responsibility of the facility manager to administer an energy management program for their respective facilities. Facility managers shall maintain an up-to-date monthly log of all utility metered readings. Reference the DoD Energy Managers Handbook. The *Energy Policy Act of 1992*, *Executive Order 12902*, and *Executive Order 12123* established the DoD mandate of ultimately reducing facility energy consumption 35% by 2010, compared to 1985 baseline levels. The *National Energy Conservation Policy Act of 2005* later superseded *Executive Order 12123*, to mandate the present goal of a 20% reduction from 2006 to 2015, compared to the 2003 baseline.
These federal mandates also authorized alternative funding methods to finance costs associated with achieving the specified reductions.

(2) Energy Conservation Investment Program (ECIP). ECIP is a DoD military construction funded program for projects over $750,000 for improving the energy efficiency of existing Army facilities or constructing new, high efficiency energy systems. ECIP projects do not compete for resources with MCA or OMA requirements. DAIM-FDF-UE conducts an annual call for ECIP project submissions in the spring of each year. DD 1391s for ECIP candidate projects should be sent to the command headquarters by 31 July of each year, so they can be forwarded

for consideration for the second following fiscal year (e.g. FY09 submissions must be submitted to MEDCOM in July, 2007). Information in the DD 1391 must include the cover sheet and a current well-supported economic analysis summary sheet. All appropriate savings from energy efficiency demand reduction, water conservation, reduced maintenance or manpower requirements, and utility rebates should be included.

(3) The Energy Savings Performance Contract (ESPC). The long term use of energy savings and performance contracts in USAMEDCOM is authorized, when administered in accordance with DA guidelines. The *Energy Policy Act of 1992* authorized private sector funding to accomplish energy saving retrofits in Army facilities. The ESPC is a contracting methodology in which a private contractor, called an Energy Services Company performs services such as facility energy audits, installation, operation and maintenance of equipment, technical services, and similar work in "partnership" with the Army. ESPCs generally function as Indefinite Delivery/Indefinite Quantity contracts in which the contractor identifies energy improvements, performs the work at a fixed price, and secures financing to pay for the improvements. The Army then repays this loan from the realized energy savings. ESPC can be used for any work that results in a simple payback of 10 years or less. The actual loan term can extend up to 25 years.

j. Space Management and Utilization

(1) General. Space management is the process of identifying and projecting space requirements, identifying deficiencies, allocating available space to users in an equitable way, monitoring use, assisting users with space usage problems, and resolving space problems. Space management also addresses quality of space. Space management functions in USAMEDCOM facilities may or may not be a direct responsibility of the facility manager. However, the facility manager is responsible for reducing the cost of maintenance, repair, and operation of facilities through better space utilization and conservation, and avoiding unnecessary new construction projects. Space management ensures each user is assigned the appropriate space. When an activity obtains excess space, waste of scarce and expensive resources occurs due to under utilization. Conversely, over utilization occurs when an organization occupies less space than actually authorized. The costs of incorrect utilization may be additional utilities and maintenance funds and potentially degraded performance of a unit that could be occupying more productive space.

(2) Goal and Objectives. The space management goal of the AMEDD is to use facilities in the most effective way for cost and mission accomplishment. Space is a resource that requires management. Failing to manage this resource can result in a loss of productivity and scarce funds. In support of the space management goal, the AMEDD has adopted the following objectives.

(a) Use existing facilities, property, and space in an efficient manner.

(b) Reduce the need to construct or otherwise acquire facilities by using existing facilities.

(c) Determine any shortfalls or excesses of assigned facilities and space consistent with activity mission.

(d) Eliminate uneconomical, high maintenance facilities.

(e) Take action to deal with shortfalls or excesses.

(f) Eliminate off-post leasing.

(g) Dispose of land, facilities, or space that is excess to our needs.

(3) Process. The process to conduct space management includes:

(a) Establishing a space utilization inventory by department or activity.

(b) Calculating space requirements by department or activity using projected workload.

(c) Identifying space allocation deficiencies and excesses by department or activity.

(d) Developing and evaluating space management options.

(e) Implementing space management decisions.

(f) Establishing a space utilization committee that is chartered to manage all space utilization issues.

(4) Excess space: Identify all excess buildings to the installation as excess to medical requirements. Do this only after coordination with our Director of Healthcare Operations and the Assistant Chief of Staff for Installations, Environment, and Facility Management. The DA medical requirements such as TO&E hospital movement or mobilization requirements, not yet known by the MTF or the installation, may be available at USAMEDCOM headquarters. As per *AR 40-2*, Army Medical Treatment Facilities General Administration, paragraph 1-10b, the installation must formally obtain our approval prior to diversion, conversion, or demolition. USAMEDCOM will not fund the operation and maintenance of any facility/space that is excess.

k. Integrated Modular Medical Support System (IMMSS)

(1) General. The intent of IMMSS is to provide a quality interior furnishings system for USAMEDCOM facilities worldwide. IMMSS is a demountable and relocatable furniture, furnishings and equipment system composed of components, including but not limited to panels, rails and vertical and horizontal wall supports, work surfaces, storage units and electrical and plumbing hardware, that is panel/rail/wall support connected and supported to provide work stations and combined to meet various functional requirements of the facility. These products enable facilities to avoid product obsolescence due to changes of operation, equipment and personnel needs. IMMSS respects this intent and provides maximum product integration and flexibility to accommodate changing medical technology and functional requirements. The products are durable, flexible, safe, have a professional appearance and are functional within the healthcare setting. IMMSS coordinates and complements the building design and other furnishing items within a facility.

(2) Product capability. A wide selection of components is provided to meet clinical, administrative, pharmaceutical and lab system, nurse station and material handling requirements. Products are modular and capable of being relocated anywhere within the facility. Components are designed to accommodate material movement in areas of large material flow. The complete line of products benefits the entire facility from multi-occupancy admin offices to clinical need areas. IMMSS provides the ability to relocate workstation components from one location to another as functions change. There are four advantages of this contract that will complement construction and renovation projects. This contract is especially beneficial when used in conjunction with a USAMEDCOM renewal project or a restoration, modernization project. A one time Federal Prison Industries waiver/exception is required. (Note: The waiver requirement is frequently reviewed and the process can change. Contact HFPA for current guidance). Various support services include:

(a) Design Services
(b) Restorative Services
(c) Inventory services
(d) Reconfiguration services
(e) Panel fabric replacement services
(f) Clinical and functional analysis services
(g) Trade-in services
(h) Transportation Services
(i) Warehousing Services
(j) Extended Installation

(3) Property Designation. Equipment provided under IMMSS is considered “personal property” not “real property” in accordance with *AR 735-5*. This means activities are required to use their core budget CEEP funds. Some exceptions may apply, (in some cases, IMMSS product may be procured with Initial Outfitting funds or transition funds when purchased under a MILCON or Capital Investment project). Under certain circumstances, extended installation resulting in modifications to the facility (real property) may be funded by alternate sources. However, IMMSS is predominantly personal property and considered equipment and paid for by the activity. Facility Managers will not normally use their "K" dollars provided by USAMEDCOM to purchase IMMSS. There are some exceptions regarding the extended installation portion of the work if the extended installation repairs or alters real property and existing real property installed building equipment. Please contact HFPA if you have questions.

I. Building Inventory Management

(1) Conversions and Diversions. The DPW has the primary responsibility for management, acquisition, and disposal of real estate (*DA Pam 420-9*). Conversions and diversions are spelled out in *AR 405-70*, paragraph 3-6. A conversion is a permanent change to a facility's design Category Codes (CATCODE). A diversion is a temporary change to a facility's current use CATCODE. Real property requirements for demolition and disposal are covered in *AR 405-90*. These actions are the responsibility of the real property specialist in the DPW. Conversions and diversions of facilities are defined in *AR 405-70*. Conversion and diversion of MTF require approval of the USAMEDCOM.

(a) *AR 405-70*, paragraph 6-3.d. (10) states: "Diversion or conversion of facilities initially constructed or subsequently converted to a Medical Treatment Facility will not be converted or diverted without approval of the USAMEDCOM for United States based facilities, or the appropriate medical command if OCONUS. See *AR 40-2*, paragraph 1-10."

(b) *AR 40-2*, paragraph 1-10.b states: "Buildings initially constructed or subsequently converted to house MTF or AMEDD personnel will not be altered, modified, or diverted from their original use without prior authority of the USAMEDCOM. Authority for conversion without provision for reclaim in the event of a requirement will be granted by USAMEDCOM where no present or future medical requirement exists. Approval of the USAMEDCOM will also be obtained prior to making any major changes in the functional arrangement or layout of any part or portion of an MTF. MTF include hospitals, troop clinics, laboratories, dental and other clinics, and quarters specifically constructed for AMEDD personnel, including civilian personnel."

(c) USAMEDCOM or MSC approval of a major repair or minor construction project constitutes approval of a major change in the functional arrangement or layout of an MTF. Based on *AR 405-70*, paragraph 3-6.e, and *AR 40-2*, paragraph 1-10.b, requests for conversion require the following items:

- Facility number
- Existing design use CATCODE
- Proposed design use CATCODE
- Justification
- Date of proposed conversion
- Signature of the installation commander
- Approval from installation medical commander
- Statement that the Integrated Facilities System Mini/Micro (IFS-M) and real property records will reflect the diversion

(d) Or the following three items:

- An unexecuted, but completed, DA Form 337
- Signature of the installation commander
- Approval from installation medical commander

(2) Category Codes. CATCODE identify the facility class and the facility category group. CATCODE for various types of facilities can be referenced in *AR 40-2*.

(3) Demolition. The DPW real property specialist must get predisposal clearances for all hospital and medical facilities before they finalized the disposal and demolition of the MTF buildings. *AR 405-90*, paragraph 6-4.d. states: "The USAMEDCOM must concur in the disposal of hospitals and medical facilities under its control (See *AR 40-2*). Disposal of such facilities not under the USAMEDCOM must have prior approval of the appropriate MACOM." Based on *AR 405-90*, paragraph 6-4.d., and *AR 40-2*, paragraph 1-10.b, requests for predisposal clearance of a MTF must include the following:

(a) Name of installation
(b) Facility number and installation number
(c) Gross square feet and UM2 of the facility
(d) Facility type (permanent, semi-permanent, & temporary)
(e) Design use and current use CATCODE
(f) Original cost and year built
(g) Justification

(h) Statement of how long the facility has been vacant
(i) Date of proposed disposal
(j) Signature of the installation commander
(k) Approval from installation medical commander

(4) Integrated Facilities System Mini/Micro (IFS-M). All buildings, including medical, are reported in the installation's IFS-M by the DPW Real Property specialist. Information in the IFS-M database includes size, age, available utilities, building materials, user, original cost, and capitalized improvements. Every quarter, the DPW real property records are downloaded to the Center for Public Works, at Ft. Belvoir, where all of the Army's real property records are kept on a system called Headquarters Integrated Facilities System (HQIFS). The Pentagon and Department of Army staff has access to the real property records through HQIFS. The HQIFS data is used by numerous decision makers and was extensively used during BRAC. Decisions regarding mobilization expansion capability, facility investment potential, and infrastructure readiness are based in part on HQIFS data. These decisions may negatively impact facility management if the HQIFS data is not accurate.

(5) Building Ownership. All buildings at your installation are “owned” by the installation Commander. The installation Commander has a Memorandum of Understanding (MOU) and an ISSA with the Medical Commander for the use of buildings at the installation. The DPW provides services (fire protection, security, utilities, real property IFS-M reporting, and possibly others, such as maintenance) based on the MOU and ISSA.

(6) Approval Process. The only person at the installation who can change the use of a building in the IFS-M database is the Real Property specialist. The Real property specialist has to obtain permission from their higher headquarters to change the use of buildings. Changing a building to, or from, a medical use category code needs approval from HQ USAMEDCOM, ACSIE&FM. ACSIE&FM also coordinates all VETCOM and DENCOM conversion requests for approval.

(7) Leases. Leases for additional space off post must be processed through the DPW and the local District Army Corps of Engineers. The lease process requires a minimum of 6 months lead-time. All Army leases are required, by law, to be processed through the Army Corps of Engineers.

(8) “Modular-type” facilities. “Modular-type” facilities can be identified as Medical Equipment, Real Property, or Relocatable Buildings. See paragraphs 8-7.l (11)-(12).

(9) Medical Equipment. Medical equipment inventory management is the responsibility of the Bio-medical Maintenance section of the MTF. Follows the equipment approval and acquisition procedures per *AR 40-61, SB 8-75-11* and *SB 8-75-MEDCASE*, for CEEP, Super-CEEP and MEDCASE. Examples of medical equipment are Bio-Safety Level 3 Facility (BSL3) units and MRI units. If the purchase price is less than $250,000, use Operation & Maintenance Defense (OMD) or OMA funds. If purchase price is equal to or greater than $250,000, use OPD or OPA.

(10) Real Property. Real property is defined as a separate and individual building, structure, utility system or other real property improvement identifiable in the three-digit category code listed in *AR 415-28* and following the requirements in *AR 415-15*. The DPW is the installation staff officer responsible for work classification and approval at the local level or forwarding to the Regional Installation management Activity (IMA) for approval action. Classification will be identified as repair, minor construction or MILCON. Sustainment, Restoration, Modernization funds (OMD, OMA, MED MILCON, or MCA) are used only for property of this category.

(11) Relocatable Building. A relocatable building is a personal property building designed to be readily moved, erected, disassembled, stored, and reused. The estimated costs for building disassembly, repackaging (including normal repair of components), and non-recoverable building components, including foundations, may not exceed 20% of the acquisition cost of the relocatable building. (See Table 8-1, Relocatable Building Validation for formula)

(a) Operating Lease: Must meet all (6) criteria:

(i) Ownership of the relocatable building remains with the lessor during term of lease and is not transferred to the Government at or after the end of lease term.

(ii) Lease does not contain a bargain- price purchase option.

(iii) Lease term does not exceed 75% of the estimated economic life of the relocatable building.

(iv) Present value of the minimum lease payments over the lease does not exceed 90% of the fair market value of the relocatable building at the beginning of lease term.

(v) Relocatable building is general-purpose, not a special purpose of the Government and is not built to the unique specification of the Government as lessee.

(vi) There is a private sector market for the relocatable building. For operating lease, use OMD or OMA funds.

(b) Capital Lease: Any lease other than a lease-purchase that does not meet criteria of an Operating Lease. NOT RECOMMENDED, capital leases require funding the entire lease up-front and withdrawing the lease payments.

(i) If less than $250,000, use OMD or OMA funds.

(ii) If equal or greater than $250,000, use OPD or OPA.

(c) Site Preparation (Site prep). Site prep for any of the “modular-type” facilities is considered installation real property and follows *AR 415-15* and *AR 405-45*. Site prep includes: foundations, exterior utilities, parking, lighting, and other construction costs. The DPW is the installation staff officer responsible for work classification and approval at the local level or forwarding to the Regional IMA for approval action. Classification will be identified as repair, minor construction or MILCON.

(d) The activity is not allowed to “keep” the building if purchased as personal property. Disposal or an approved reuse plan is the only options available at the end of the approved period of use. In extremely rare instances a relocatable building may be converted from personal property to real property with approval through the funding MACOM, the Center for Public Works and the Office of the Assistant Secretary of the Army for Installations, Logistics, and the Environment.

Table 8-1
Relocatable Building Validation
Percentage (f) = (a + b + c + d) / (e) * 100

	(a) ($000)	(b) ($000)	(c) ($000)	(d)† ($000)	(e) ($000)	(f) (%)	(g)‡	(h)‡
Facility Type (e.g., barracks, admin, classroom, dayroom, arms room, maintenance, laundry, latrine, storage)	Building Disassembly (disconnect and removal from foundation)	Repackaging (including normal repair, refurbishment of components)	Non-recoverable Building Components (fasteners, seals, skirting, anchors, etc.)	Foundation	Purchase Cost of Relocatable Building (including delivery and set up)	%	Facility is relocatable (≤20%)	Facility is Real Property (>20%)

Notes:

† "Foundation" includes blocking, footings, bearing plates, ring walls, and slabs. For the purpose of this calculation, "Foundation" does not include construction cost of real property utilities, roads, sidewalks, parking, force protection, fencing, signage, lighting, and other site preparation (clearing, grubbing, ditching, drainage, filling, compacting, grading, and landscaping).

‡ If the percentage in column (f) is less than or equal to 20%, enter "Yes" in column (g). If the percentage in column (f) is more than 20%, enter "Yes" in column (h).

All requests for relocatable buildings must be provided on the Relocatable Building Request Worksheet to the DPW for approval action.

See Table 8-2 for approval authorities.

Table 8-2.
Personal Property Relocatable Building Approval Authorities [1]
(*AR 420-18*) (*OMB Cir. A-11*)

Relocatable Building Action	Director Installation Management Activity (IMA) and MACOM Commander (for areas outside of the geographic boundaries of HQ IMA)	DASA (I&H)	Office of the Secretary of Defense (OSD)
Lease or Contractor-Provided	**Time:** Not to exceed 1 year and **Cost:** Not to exceed $100,000.	**Time:** Greater than 1 year and less than 3 years **Cost:** Greater than $100,000 per year	**Time:** Greater than 3 years
Extension of Existing Lease	**Time:** Not to exceed 1 year and **Cost:** Not to exceed $100,000 per year (maximum of 3 years).		
Transfer to Other Locations	**Time:** Not to exceed 1 year and **Cost:** Not to exceed $100,000 per year.		
Option-to-Renew Clause	**Time:** Not to exceed 1 year and **Cost:** Not to exceed $100,000 per year.		
Purchase as Personal Property	No Authority	**Time:** Greater than 1 year and less than 3 years	**Time:** Greater than 3 years

For purchase of relocatable less than $250,000, use OMD or OMA funds. If purchase price is equal to or greater than $250,000, use OPD or OPA for lease of the relocatable building.

[1] All authorities are on a "per lease" basis.

m. Equipment Site Preparation.

(1) General. Equipment site prep is a responsibility of the Facility Manager. Facility Managers coordinate and develop requirements for installation of Super-CEEP and MEDCASE equipment purchases.

(2) Planning and Coordination.

(a) Planning for site prep should begin during initial equipment programming. Funding to support Super-CEEP and MEDCASE site preparation is centrally managed at ACSIE&FM. Site prep should be completed prior to the equipment delivery date.

(b) Repair or minor construction projects to support failing infrastructure, aesthetics or functional requirements should be planned and programmed as SRM projects and timing should be in coordination with site prep activities. Funding to support repair or construction projects in support of these equipment purchases are addressed in *this SB*, Chapter 8 paragraph 8-9 d: "All projects will be submitted to the MSC for validation, approval and regional prioritization. Upon approval, the MSC will prioritize and fund the project based on funds available and if it is within specified funding range. Currently, this range is $25,000 to $300,000. Projects greater than $300,000 will be forwarded by the MSC directly to ACSIE&FM for approval. The ACSIE&FM will release funds for approved projects. Projects will be funded in accordance with the MEDCOM prioritizing scheme and the MTFs ability to execute." Items purchased for MILCON projects are exempt from the site preparation program.

(3) The following list, though not all inclusive, provides guidance on what qualifies for site prep.

(a) Site preparation consists of providing the means to physically attach the piece of equipment to the real property MTF, which may include plumbing, cabling, or wiring necessary for the specific piece of equipment.

1) Secondary utility work necessary to connect the equipment to existing utility services within the building. This work lies between the primary entry or source within the building and the room in which the equipment is to be placed.

2) Installation of air conditioning for types of equipment where the manufacturer's written specifications states that the equipment must be operated in an air-conditioned space and provides temperature and/or humidity parameters which cannot be sustained by existing air conditioning.

3) Provision of false floors or platforms required solely for the operation of the equipment.

4) Installation of required shielding for electromagnetic radiating devices such as X-ray machines and linear accelerators. This includes wall construction with lead lined sheetrock.

5) Temporary removal and reinstallation of items such as portions of walls, roof, and utility systems to permit installation of equipment. Reinstallation may involve rerouting or relocation of some items.

(b) Most work eligible for funding as site preparation will be classified as "non-construction" (i.e., engineer's "M" cost account, municipal services) by the DPW on the work request (DA Form 4283). The DPW is responsible for properly segregating and classifying all work.

(c) Site prep that adds real property outside the footprint of the MTF, such as a foundation and utilities for a Relocatable building, will be considered construction, NOT site prep.

(d) Only that work which is specifically required to make the piece of equipment operate is eligible to be funded as site preparation. Work generated to repair failing infrastructure, or for aesthetic or functional reasons will NOT be funded with site prep funds.

(e) The repair or minor construction work associated to repair failing infrastructure, improve aesthetics or functions may be performed in conjunction with the site prep work, but funding and approval will follow the procedures of this SB, paragraph 8-9.d. d.

(f) The transportation, assembly, installation, calibration, and testing of the equipment are NOT site prep costs.

(4) Funding policy:

(a) Site prep funds support equipment purchased through Super-CEEP and MEDCASE Programs. Items purchased for MILCON projects are exempt from this program.

(b) Site prep costing less than $1,000 will be financed from local resources.

(c) Activities are not authorized to reprogram site prep funds to any other requirement unless such reprogramming is approved by the ACSIE&FM.

(d) The following documents are required to be submitted to the ACSIE&FM site prep point of contact for site prep funding release:

(1) An approved DA Form 4283 identifying work classification and approval amounts.

(2) Completed Site Prep Categories spreadsheet

(3) Scope of work and cost estimate of site preparation to be completed.

(e) Site preparation funding will be distributed via Financial Authorization Document (FAD) and will be accounted for under *Army Management Structure Code* (AMSCO) *847714.87*

n. Support Agreements.

(1) For Inter-Service Support Agreements (ISSA), the FM should reference DD Form 1144 and *AR 5-8*. The ISSA designates a supplying and receiving activity, and governs services required from the providing agency to the receiving agency. As such, resource managers and Commanders or their designated representatives usually sign it. The proponent for the ISSA is Resource Management. For each support category, a basis for reimbursement and estimated reimbursement amount are provided. Support categories that are usually related to facility management functions are:

(a) Common Use Facility Operations, Maintenance, Repair and Construction

(b) Facility Maintenance and Repair of Real Property and Space Management

(c) Utilities

(2) MOA. The FM should include the following when developing a draft MOA:

(a) Detailed Standard Level of Service (includes compliance standards, such as Joint Commission, response times, quality assurance)

(b) Quantity

(c) Frequency

(d) Basis for Reimbursement (Includes basis of payment, method of payment transfer, rate scheme)

(3) Basis for Reimbursement. Basis for reimbursement can be complicated when installation facility support services are supplemented with contract support services. The FM is responsible for working with the RM and the supplying agency, in most cases the DPW, on development of a basis of reimbursement that offers the greatest economy, efficiency, and flexibility. Costs, such as annual fees, special service rates, and internal and external overhead, may be immediately apparent from the ISSA reimbursement schedule. A clause should be included giving the receiving agency, such as the MTF, the authority to use an alternate supplier, such as an outside contractor, if the supplier cannot meet the conditions stipulated in the ISSA. This is commonly referred to as right of first refusal.

8-8. O&M PROJECT MANAGEMENT

a. General: Project management consists of planning, programming, budgeting, and executing sustainment, restoration and modernization projects. This section applies to major repairs for projects over $25,000. Projects that are under $25,000 are considered minor repairs. Minor repairs are managed as part of the activity's recurring maintenance and minor repair program (i.e., R-Line distribution).

b. Minor Construction: Reference 10 U.S.C. Section 2805 (*Public Law 107-107*), *AR 420-10*, Management of Installation Directorates of Engineering and Housing, 2 Jul 87, and *AR 415-15*, Army Military Construction Program Development and Execution, 30 Aug 94. The threshold for minor construction projects is $750,000.

c. Life, Health, or Safety: A special threshold for minor construction projects to correct life, health, or safety deficiencies became effective with Section 2801 of *Public Law 107-107*. Effective with the President signing the FY02 Defense Authorization Act, Section 2805 of *Public Law 107-107* provides special threshold for unspecified minor construction projects to correct life, health, or safety deficiencies. The limits are not retroactive. The limits are as follows:

(1) The minor MCA subsection of the Law adds the following: "However, if the military construction project is intended solely to correct a deficiency that is life-threatening, health-threatening, or safety-threatening, a minor military construction project may have an approved cost equal to or less than $3,000,000." Medical Unspecified Minor Construction (UMC) projects will be submitted to:

Health Facility Planning Agency (HFPA)
5109 Leesburg Pike, Suite 679
Fall Church VA 22041-3258

Submission of UMC projects must be accompanied by photos, clear description of the project requirements, and justification identifying the life-threatening, health-threatening, or safety-threatening deficiencies.

(2) O&M statutory limitations on the new work portion of an SRM project:
(a) $1,500,000, in case of a project intended solely to correct a deficiency that is life-threatening, health-threatening, or Safety threatening; or
(b) $750,000, in the case of any other project.

(3) IMA or MACOM Commanders can approve the new O&M limit or delegate it to their Delegation of approval authority is to be in writing. The new special threshold does not change any other approval limits or work classification requirements. The local DPW maintains the responsibility for work classification. However, it is the responsibility of the Facility Manager to justify deficiencies that are questioned by the DPW. ACSIE&FM will assist the MTF in stating the life-threatening, health-threatening, or safety-threatening deficiencies and endorse the need for valid projects

d. USAMEDCOM Approval Process: The local Facility Managers, with approval from their Commands, submit all projects over $25,000 to the RMC/MSC for validation, approval and regional prioritization. Upon approval, the RMC/MSC will prioritize and fund the project based on funds available and if it is within specified funding range. Currently, this range is $25,000 to $300,000. Projects greater than $300,000 will be submitted by the RMC/MSC to ACSIE&FM as a Major Repair and Renewal (MRR) Project. The request for submission of unfunded MRR projects for the budget year plus 2 years will be requested annually via a data call in April of the current year. Facility Directors are responsible for obtaining Command approval of their program prior to submission to ACSIE&FM. Emergencies or urgent requirements identified in a current fiscal year that cannot wait for annual submission will be submitted through the RMC/MSC Facility Director to ACIE&FM for evaluation for insert into the current year program. Each request will include a justification of the emergent/urgent requirement and where in the regional priority list it will be inserted. During the fiscal year, when a project is ‘ready’, funding for a MRR project will be released via FAD to the MTF.

e. Department of the Army Approval Process. Any repair project must have an approved DA 4283 work request and/or Maintenance & Repair (M&R) DD 1391 for the work being performed. It is the DPW/Garrison Commander's responsibility to classify work as maintenance, repair or new work (construction). An approved DA 4283 must be signed by authorized DPW personnel for the repair and/or construction of the project. Work classification ("K" & "L") should be identified on this document. If the repair ("K") work

exceeds $3M or the work exceeds 50 percent of the replacement value of the facility greater than $500,000, then a Maintenance and Repair (M&R) DD 1391 must be developed and approved by the Department of the Army. Form DD 1391s are developed by the local DPW and forwarded up to the regional IMA. The Regional IMA will review the DD 1391 and forward it to Headquarters, IMA who forwards the DD 1391 to the Army Chief of Staff for Installation Management (ACSIM). Final approval is given by the Deputy Assistant Secretary of the Army (DASA) Installation and Housing. If the repair DD 1391 exceeds $7.5 Million, then Congress must be notified 21 calendar days before project approval is given by DASA (I&H). M&R DD 1391s only approve repair work, if there is new work (construction) associated with the project within O&M limits, this work needs to be approved on a DA 4283.

f. Medical Facility Support Program. The Medical Facility Support Program allows FMs and USAMEDCOM DPWs access to a number of innovative and cost-effective operations, maintenance, repair, minor construction contracts as well as a variety of facility-related services. The compilation of these contracts is called “toolbox”. Toolbox contracts are in place at selected contracting activities called “Medical Support Teams” (MSTs) that meet the regulatory requirements under the Economy Act and Intra-DoD Offloading. The USAMEDCOM and has established MOUs with MSTs. This allows MTFs to obtain operations and maintenance and other support services on a timely and cost effective basis. The DPW must be offered reimbursable projects prior to obtaining the services from alternate sources. Toolbox allows the FM and DPW a way to accomplish mission requirements. The USAMEDCOM TOOLBOX manual provides guidance on planning, executing, and administering work within the Medical Facility Support Program.

g. Responsibilities.

(1) HFPA

(a) Provide Medical Support Commands and Regional Support Commands with annual programming guidance and criteria for development of medical facility projects and programs.

(b) Provide Program Analysis and Evaluation for the Medical MILCON Program.

(c) Perform Master Plans and special studies for AMEDD facilities

(d) Develop planning and justification packages for Medical MILCON Projects.

(e) Perform clinical and technical reviews of Army medical facility designs (regardless of funding source) for medical functionality.

(f) Validate workplans IAW DoD medical facility criteria and gain necessary waivers thereto.

(g) Submit the proposed Army medical facility program to the ASD(HA) Portfolio Planning and Management Division

(h) Monitor and analyze medical construction program execution.

(i) Manage the Unspecified Minor Medical MILCON program.

(j) Provide additional assistance in project development, management, criteria evaluation/application, and construction quality assurance as resourcing allows.

(k) Manage, in conjunction with ACSIEFM, the Transition Project Support program.

(2) ACSIE&FM. ACSIE&FM has the responsibility for management of project support services and the toolbox program. ACSIE&FM will:

(a) Identify MSTs to provide the acquisition and engineering/technical support for toolbox and negotiate MOUs.

(b) Identify and provide scopes of work to MSTs for those services that are required by FMs support operations and maintenance.

(c) Issue and maintain the toolbox manual.

(d) Provide technical assistance to the FMs using project integrators.

(e) Coordinate COR duties in support of the contracting officer.

(f) Provide technical assistance to FMs in preparation of development of work plans and cost estimates.

(g) Review request for contract services from FMs and forward to MST.

(3) Facility Managers. FMs will:

(a) Develop internal procedures for implementation of toolbox contracts.

(b) Establish working agreements with the DPW and other host installation support activities for processing work requests and obtaining approval for reimbursable projects.

(c) Identify to ACSIE&FM any additional services desired for inclusion into toolbox.

(d) Insure the complete requests for services packages are prepared for processing through the MSTs.

(e) Maintain a file of each delivery order issued by the contract POC for the activity.

(f) Provide required level contract management of each project.

(g) Provide the contract POC a receiving report or completion of services statement, as required.

(4) DPW Interface. The DPW must:

(a) Receive requirements for the FM.

(b) For approval of repair work or new work, return approval to the FM with a DPW signed work request, DA 4283, showing work classification, K, L, etc.

(c) Accomplish work by:

- In-house work forces or other pre-established contracts.
- Competitive bid.
- Accomplish work using toolbox contracts.

h. Work Plans. Work plans are an alternative means of project execution in lieu of the lengthy process of full-scale project design and execution. The contractor generates a work plan for the project based on a site visit and a written scope of work. This work plan is provided to the FM for review and comments. The FM must obtain all local reviews and coordinate the return of all comments. The work plan includes these items. Some of these can be waived on small and uncomplicated projects.

(1) Executive summary providing a brief description of the work
(2) Narrative description of work required, referencing study and design calculations
(3) Sequential listing of steps required for the project execution
(4) Work schedule
(5) Drawings, as applicable
(6) Standards and engineering specifications
(7) Engineering calculations and analysis
(8) Scope of work
(9) Material take-offs
(10) Catalog cuts and equipment specifications
(11) Manufactures and installation procedures or execution specifications
(12) Outline of training
(13) Outline of O&M documentation
(14) Video of site

i. Work Plan Coordination. Reviews and coordination of SRM project work plans and/or design must be efficiently accomplished in order for toolbox major repair and minor construction projects to meet project goals and maintain schedule. This reduces the need for costly modifications and delays during the construction phase. All functional areas within the MTF should be involved in the reviews. Reviewers will screen proposed work plan for conflicts and/or omissions within their functional area. They should provide written comments in the Corps of Engineers comment review format (DrCheck's software program, www.Projnet.org) within the suspense time set for the review by the Facility Manager. The Facility Manager will compile and forward comments to the appropriate Corps of Engineers District. The work plans should be reviewed in the following functional areas as applicable to the size and type of project:

FUNCTIONAL AREA	REVIEW AGENCY
- Facility O&M	Facility Manager
- Physical Security	Phys Sec Br/ PMO
- Information Systems	Info Mgmt Office
- Environmental Health	Occupational Health
- Safety	Safety Officer
- Fire Safety	DPW
- Environmental Assessment	DPW
- Historical Compliance	DPW
- Utility System Standards	DPW
- Mechanical System Standards	DPW
- Technical Engineering Criteria	DPW
- Installation Design Guide	DPW
- Medical Functional	Space occupants and HFPA
- Environment of Care	HFPA
- DoD Criteria	HFPA

8-9. MILITARY MEDICAL CONSTRUCTION

a. Major recapitalization projects may be programmed through various sources depending on the justifications.

b. Regulatory Basis. *AR 415-15*, Army Military Construction Program Development and Execution, establishes Army policies, responsibilities, and procedures for the development and execution of MCA and Unspecified Minor Military Construction, Army programs. Section 1-20 of *AR 415-15* specifies responsibilities of The Surgeon General in Medical Military Construction Programs. *DA Pam 420-9* shows an MCA program development flow chart, illustrating the process for MCA program design through execution.

(1) Projects for construction of new or replacement facilities costing more than $750,000 must be submitted to Congress for. The process for preparing the documentation for Congress is known as construction programming. Typically the installation master planner who works within the Directorate of Public Works prepares this documentation. Installation master planning supports the process by coordinating and preparing the 1391.

(2) Medical Construction programming is divided into several funding categories. The medical construction program (MED MILCON) is used to fund construction of new, or expand, clinics, hospitals, medical training facilities, and medical research facilities. MCA is used to fund the construction of barracks, administrative buildings, childcare centers, and many other types of non-medical projects. Additionally, Army funding from MCA and BRAC may fund construction, replacement and/or expansion of medical facilities.

c. Requirements Identification. Identifying requirements for the MED MILCON program is the responsibility of the entire Army Medical community. Once identified, MED MILCON projects are included in either the Future Years Defense Plan, or the Long Range Plan. The objective of a 50-year life cycle for the medical infrastructure can only be achieved if requirements for construction projects are identified early in the planning process and supporting documentation is carefully completed. All projects must have as a minimum a front page DD 1391 entered into the 1391 processor system, which accurately portrays the requirements, scope and cost for the proposed project.

d. MED MILCON Development. To develop the MED MILCON Program, each year the ASD(HA) requests a prioritized listing of all requirements for MED MILCON projects for a six year period. The Army's listing of projects is developed by the MSCs and submitted through the USAHFPA and the Army Staff to ASD (HA). Typical projects include:

(1) Complete replacement of a facility. Criteria for a justification for a replacement facility include:

- There is an additional mission.
- The current facility is substandard and cannot pass accreditation (even if the Life safety Upgrades (LSU) or Addition and/or Alteration (ADAL) is performed.
- An economic analysis identifies a new facility as more cost effective than the LSU or ADAL.

(2) Consolidation of two or more freestanding facilities. Consolidations generally occur when two or more facilities are required for one mission. Justification for consolidation depends on the condition of the facilities and the impact numerous facilities have on the mission.

(3) Addition and/or alteration (ADAL) to an existing facility. An ADAL is required when space, services, or systems are required in addition to the existing facility. This assumes that the existing facility is in adequate or repairable condition.

(4) Life safety Upgrades (LSU): LSUs are required when NFPA standards are not met, or when the facility cannot obtain Joint Commission accreditation. Generally, Joint Commission accreditation is not obtained due to facility deficiencies, which cannot be remediated with simple repairs or corrections.

e. Documentation. Validation documentation required for a MED MILCON project:

(1) Project Planning Package/1391. The DD 1391 is used to officially request project authorization and appropriation by Congress. As soon as a MED MILCON requirement is identified, a DD 1391 should be initiated at the Installation level. The MED MILCON program is a six-year program. The fiscal year of execution of a MED MILCON project can be estimated to be six years from the time of project identification. The fiscal year of execution will be adjusted annually, as the MED MILCON project develops. With few exceptions, such as a Congressional insert, DoD requires that project identification be at the 35 percent design (concept) stage before the DD 1391 is submitted to Congress.

(2) Project Narrative. Project Narrative summarizes the sizing decision process, siting, significant planning information and results.

(3) PFD. Program for Design, (PFD), space program, including the required number of parking spaces.

(4) Equipment Planning. USAHFPA is responsible for planning for installed (built-in) medical and dental equipment and the associated MILCON budgeting to support this requirement. HFPA shall provide the MTF with an initial equipment listing based on the Program For Design for their review and input prior to furnishing the document to the Design Agent. Each equipment list may be tailored or modified by the using Military Department as appropriate. Equipment in Logistical category Codes E and F may be altered by the using Military Department if funding source requirements are not exceeded.

(5) Project Book. The Project Book summarizes existing site conditions and utilities. The following information, at minimum, is required:

(a) Area maps, location maps, site location, site description (to include grades, gates, etc), style of architecture, construction season limitations, seismic, wind and snow considerations, SOFA, host country agreements, soil and foundation conditions, utility conditions (water, sewer, power, steam, electrical capacities and location), site restrictions (airfield, AICUZ potential helipad approach/departure zone obstructions, flood land, rights-of-way, etc.), and National Capitol Planning Region considerations, etc.

(b) Utility availability, existing fuel sources, central heat or chilled water systems and capacities, power service characteristics and locations, electrical distribution, water and wastewater considerations.

(c) Environmental impact requirements, archaeological and historical considerations, explosive ordinance locations, contaminated soil (fuel, asbestos, etc.), coastal zone considerations, wetlands and watershed considerations, threatened and endangered

species considerations, water quality, air quality, asbestos contamination, protection of natural resources information, and any other EPA or OSHA considerations necessary which might impact the MILCON project.

(d) Security requirements, contingency or blast considerations and Anti-Terrorism / Force Protection (AT/FP) requirements.

(e) Fire protection considerations, such as accessibility and water supply.

(f) Communications, information or data systems, telephone and signal interface requirements for fire, police, etc., telephone switch capacities and line availability for MILCON project, Energy and Utility Monitoring and Control System (EMCS, UMCS) interface, master antenna, cable TV and closed circuit availability, computer interface, and all other similar or useful information.

(g) Preliminary analysis of replacement versus addition/alteration where requested by DMFO.

(h) Completed site survey.

f. MILCON Project Space Management: The MILCON replacement of a facility always draws auditors and high-level command interest and requires special emphasis. The cost-effective reuse/demolition of the old facility is always one of the major items of interest. It is mandatory to complete the following procedures at least 12 months prior to occupancy of the new facility. Once completed, update the process periodically until final disposition of the old facility occurs.

(1) Establish a space utilization inventory for new and existing facilities by department or activity. The space inventory already exists for new facility in the form of the PFD. The PFD is the space program that the architect used to design the new facility. The PFD identifies assigned personnel (included are the contract and partners if identified during the programming stage) and the room or space required by these personnel and their activities. If the MTF does not have an existing inventory of assigned space, the MTF must develop it. If a building is excess, determine only the buildings gross area. This will identify all known excess facilities and provide a departmental inventory of assigned space for all activities not included in the new facility.

(2) Calculate space requirements by department or activity. This requirement already exists in the PFD. The HFPA prepare the PFD to meet the DoD medical space planning criteria. The only activities not covered by the PFD should be as a result of new missions or activities purposely not included in the new construction. Calculate the space requirements for these activities using the DoD Medical Space Planning Criteria (MSPC). This criterion exists in a PC-based, automated format that is available from HFPA. The DoD MSPC is contingent upon optimal conditions at a medical center. Because of this, you may find that the criteria are above what your MTF actually requires. This will not be unusual especially at community hospitals. In those instances, use your professional and clinical common sense to establish a requirement that meets the needs of your activity. There should be few, if any, instances where the planning criterion does not provide sufficient space.

(3) Identify space allocation deficiencies and excesses by department or activity. This step is simply a comparison of the space inventory versus the space requirements. This will identify space deficiencies and excesses.

(4) Develop and evaluate space management options. There are basically three ways to satisfy space deficiencies.

(a) Consolidate into the best existing facilities. The activity must begin by evaluating existing facilities to determine if any remaining facilities can satisfy the space deficit. If renovation is necessary, compare the renovation cost to the cost of new construction and leasing. If renovation is the most cost-effective solution, the activity must consolidate into the best facilities. In no instance will a World War II wood building be acceptable as a medical facility. Vacate all World War II wood buildings as soon as possible and find other facility solutions to replace them.

(b) New construction, permanent, or temporary: If acceptable existing facilities are not available, take steps to initiate new construction projects. This can be done as a

submission to our minor construction program (greater than $25K but less than $750K of new work); the Unspecified Minor Construction Program (greater than $750K but less than $1,500,000); or the construction is not possible in the required time, a temporary facility may be the interim solution. In all instances, an Economical Analysis of renovation versus new construction versus lease must be available.

(c) Lease. If leasing is a viable option, the Economical Analysis must prove that it is the most cost-effective solution.

8-10. FINANCIAL MANAGEMENT

a. General. Facility managers shall adhere to financial guidance published by ACSIE&FM and ACSRM on an annual basis, and any SRM and real property services policies issued by the DCSRM. All transfers of funds into and out of SRM Accounts (Resource Summary Programs R, S, and X) require HQ USAMEDCOM, Office of the ACSIE&FM approval. Reference DFAS-IN Manual 37-100-xx (year), OMD funds are to be used for all facilities in the DHP inventory. All new work less than $25,000 will be charged to the activity mission core funds.

b. Facility Restoration and Modernization.

(1) General. Restoration and Modernization provide resources for improving facilities. Restoration includes repair and replacement work to restore facilities damaged by lack of sustainment, excessive age, natural disaster, fire, accident, or other causes. Modernization includes alteration of facilities solely to implement new or higher standards (including regulatory changes), to accommodate new functions, or to replace building components that typically last more than 50 years (such as foundations and structural members).

(2) Program X. Restoration and Modernization is distributed under the Program X of the Resource Summary through the major subordinates command or directly from HQ USAMEDCOM. Restoration and Modernization projects, termed renewal projects, which have a sustainment component, will be executed as restoration and mode.

(3) Minor Construction. Minor Construction (“new work”) over $25K is part of Restoration and Modernization. Statutory limitations on minor construction projects are still in place under SRM. New work that is less than $25K shall be funded with Program M and not with Program R dollars.

c. Sustainment.

(1) General. Sustainment funding is programmed specifically for the routine maintenance, minor repair, and major scheduled repair of category 500 and certain non-category 500 buildings to the five-foot line. This includes regularly scheduled adjustments and inspections, preventive maintenance tasks, and emergency response and service calls for minor repairs. It also includes major repairs or replacement of facility components (usually accomplished by contract) that are expected to occur periodically throughout the life cycle of facilities. It does not include repairing or replacing equipment in place (i.e., small refrigerators or X-Ray machines) or furniture, or building components that typically last more than 50 years (such as foundation and structural members), or housekeeping contracts.

(2) Program S and R. Sustainment is distributed under the Programs R and S of the Resource Summary through the MSCs or directly from HQ USAMEDCOM. The use of Program R funds is limited to direct cost of maintenance and minor repairs of building components. It is not meant for new work that alters or renovates areas or upgrades systems to higher standards. The Facility Sustainment Model (FSM) is the basis for generating the funds for the Program R distribution. Program R funds shall not be used to fund core facility management branch staffing positions unless they are directly assigned to maintenance activities or quality assurance inspections of maintenance activity. Facility Management Branch employees

assigned and authorized on the TDA are Program M funds and are not paid out of R Line. Program R funds should be allocated and monitored by the Regional Facility Director.

(3) Scheduled Major Repairs. The use of Program S funds is limited to scheduled major repairs of building components that have reached their life expectancy. Program S includes major repair projects funded from the RMC $25-300k funds. RMC $25-300k funds that are used by the region for restoration or modernization projects are converted to the X program through ACSIE&FM. The availability of the funds for major repair projects may be dependent upon the severity of the decrease in funding level. ACSIE&FM will approve funding projects above $300k based on priority ranking and availability of funds. Regional and local RMs should not fund projects greater than $300k with Program M funds without ACSIE&FM approval.

(4) FSM and Maintenance Contracts. Existing maintenance contracts that do not have separate contract line items for work other than routine maintenance and minor repair, such as plant operations or ground maintenance shall be modified with new contract line items. Any changes to existing maintenance contracts shall not cause an increase in the approved Program R funding level. New maintenance contracts shall also be designed accordingly to be within Program R funding levels. OSD FSM model does not have a requirement for plant operations, grounds maintenance OSD specifically excludes: “custodial services, grass cutting, landscaping … .” from the Sustainment definition and states it should be part of facility operations.

d. Capital Investment. MEDCOM real property investments in excess of statutory limits for the use of O&M funds for new work will typically be programmed as MED MILCON. Responsibility for this program rests with HFPA (see paragraph 8-9.) The MTF in concert with the MTF Master Plan development will identify long range MILCON initiatives through the RMC for corporate programming and support. Completion of a DA Form 4283 is recommended, though the project will require a DD Form 1391 for approval above MEDCOM and the Installation. HFPA will program for all related funds to support the project, including design, Initial Outfitting, and Transition.

e. Real Property Services. Real Property Service includes the cost of utilities, plant operations, municipal services, fire and emergency response services, and facility engineering services. Facility managers should consult their respective Resource Manager to ensure utility payments are based on actual metered costs for those buildings that are metered.

f. Environmental Program. Environmental dollars are “fenced” and can be used only for environmental projects. This program has high visibility. Execution is monitored against programmed requirements identified in the Environmental Program Requirements-USAMEDCOM (EPR-M) and the Environmental Program Requirements (EPR) data submittal for DHP dollars, respectively. DHP environmental dollars are distributed through Program E of the Resource Summary and are based on requirements identified in the EPR-M. Movement of Program E dollars between activities will be coordinated with the ACSIE&FM Environmental Office.

g. Prior Year Funding. Projects awarded but not completed in the same year may require prior year dollars for within scope modifications. Send requests for prior year funds to your local resource manager. If funds are available, your resource manager will use the documentation to fund the increase. If funds are not available locally, forward the request to ACSIE&FM, or contact ACSIE&FM POC at 210 221-8077 or DSN 471-8077.

h. Site Preparation. Refer to paragraph 8-9e of this chapter for financial limitations of equipment site preparation.

8-11. REGULATORY CONTROLS AND ACCREDITATION

a. General. The FM shall be responsible for ensuring that all buildings are in compliance with regulations, codes, and accreditation standards applicable to the building's construction type and function. In all cases, the buildings shall comply with the Life Safety Code, NFPA 101. All buildings that house patients or in which patients receive treatment shall remain in compliance with Joint Commission standards. For research facilities, the FM shall comply with all applicable accreditation organizations, such as the CAP, and the AAALAC.

b. Regardless of whether the facility must be accredited by the Joint Commission or not, the FM shall be responsible for the development of a Utility Management Performance Plan (UMPP) and coordination of pertinent sections of all other required performance plans. The UMPP shall cover:

(1) FM Responsibilities, Organization, & Staffing
(2) Systems Overview and description
(3) Facility Training program and requirements
(4) Critical Systems List and inventory
(5) Maintenance procedures
(6) Emergency preparedness procedures
(7) Testing Requirements
(8) Performance Indicators

c. Environmental Management.

(1) Refer to *AR 200-1* and *AR 200-2*. Within the context of the facility manager's organizational span of control, the facility manager, the Chief of Logistics, the Safety officer, and the ESO are the primary personnel responsible for environmental compliance in USAMEDCOM facilities. Environmental compliance at the installation is the responsibility of the installation Environmental Division who often is part of the Directorate of Public Works. All regulatory issues should be coordinated through the ESO.

(2) Environmental Compliance on Projects: It is the facility manager's responsibilities to make sure that scope of all major repair projects include environmental abatement, such as asbestos, lead paint, etc. where required. If not sure of the extent of environmental mitigation, the facility manager should have test performed for verification.

d. DoD Medical Standards. DoD Medical Space Planning Criteria, DoD Medical Guideplates, and *UFC 4-501-1, Design: Medical Military Facilities*, provide guidance for the planning, design, and construction of replacement MEDCOM health care, research and development, and medical education facilities. These standards provide the basis for HFPA's development of MED MILCON projects which are verified by PPMD. They also are guidance for the planning of various SRM projects, both medical functional Renewals and infrastructure repairs and upgrades. The Clinical and Technical Section (CaTS) of HFPA validates projects to ensure requirements are met, and assist with the development of alternative solutions where site conditions don't allow full compliance.

e. Acquisition regulations.

8-12. MEASURING PERFORMANCE

In addition to FLCM, the USAMEDCOM Facility Strategy is influenced by the practice of management via a "Balanced Score Card" (BSC). The Surgeon General of the Army/ USAMEDCOM Commander has instituted the use of the BSC as the strategic management tool. It is the bridge to operational actions that realize strategic goals and objectives. Facility management performance is based on both internal program review and external benchmarks. Internal program review for facility management operations is accomplished through the CLRP, as prescribed by *AR 11-1* and *USAMEDCOM Pam 700-1*.

8-13. FACILITIES/LOGISTICS COMMAND REVIEW PROCESS

a. General. Facility managers are responsible for facilitating, providing input into, and follow up actions related to this process and other required staff assistance visits. The Facility Assistance and Assessment Support Team (FAAST) is the link between ACSIE&FM and this process with respect to the assessment of facility management operations.

b. FAAST Objectives. The FAAST provides assistance, assessment, feedback, and oversight relative to FLCM. The FAAST's services are not limited to just the CLRP and include the following:

(1) Provides comprehensive expertise to FMs and Commanders of USAMEDCOM MTFs in support of the Facility Management function.

(2) Supports Commanders against liabilities from outside agencies, such as OSHA, EPA etc.

(3) Assists and trains the FM organization at the MTF level on how to meet and/or exceed the required standards, and to prepare for the Joint Commission and other accreditation surveys.

(4) Provides organized management tools to identify, prevent or eliminate problem areas. Those tools include a roll up of systemic issues and problems to the Facility Directors and Command staff.

(5) Record and communicate the successes of the MTF so other MTFs can benefit.

c. Types of Visits. Types of visits include the Command Logistics Review Team (CLRT), the Organizational Assistance Program (OAP), the Organizational Inspection Program (OIP), Staff Assistance Visits (SAV), Facility Manager Support Visits and other visits, as required.

(1) CLRT: The objective of the CLRT is to periodically review facilities on 36 months or less basis. Visits are both unscheduled and requested.

(2) Facility Manager Support Visit: It is required that a visit be scheduled between 4 and 6 months after a new FM is hired.

(3) OAP/OIP: Organizational Assistance and Inspection Programs are requested by various agencies, such as the Inspector General. These requests can be generated at the USAMEDCOM or regional level.

(4) SAV: Staff Assistance Visits may be requested by facility managers, or facility directors through ACSIE&FM. SAVs may also be directed by ACSIE&FM.

d. Survey Process.

(1) Preparation for a visit: Approximately 60 days prior to a FAAST visit, an introduction e-mail will be sent directly to the FM from the FAAST. The email will provide an itinerary, a copy of the last visit's report, and checklist for the FM to review. If the visit is in conjunction with a formal review team, such as a CLRT, OAP, etc, the OIC of the team will send a formal letter to the C, LOG or the Command Group through proper channels depending on what type of visit will take place. It is the responsibility of the facility manager to self-assess their organization using the prescribed checklist. The self-assessment should be completed and returned two (2) weeks prior to the visit along with any issues the FM may have so the FAAST can be prepared to address them and work to help solve them during the visit. In addition to the copy of the previous report, checklist and the self-assessment, the FAAST will also review other reports prior to visiting a site such as:

- The current “Vanderweil Facility Advisors” (VFA) assessment to include the FCI
- TRACER
- The current Installation Status Report (ISR)

(2) Checklist

(a) The first part of the visit is spent going through a comprehensive checklist, not just to answer the questions, but to go over the self assessment in detail, review the supporting documentation, such as testing/inspection logs, DMLSS report and other records, and address any issues that the FM or FAAST may have.

(b) The objective of the checklist is to measure the success of USAMEDCOM facility management programs. The checklist focuses on efficiency, effectiveness, and adherence to USAMEDCOM accepted business practices and regulatory compliance. It also provides guidance in the implementation of facility management programs at the activity level, and helps to determine the root cause of a given situation, problem or issue. The checklist is meant to be a working document that is periodically reviewed and modified as required.

(c) The checklist is divided into the following categories:

- Organization Administration and Training
- Resource/Financial Management
- Operations and Maintenance
- DMLSS-FM
- Project Management
- Physical Plant and Site Survey

(3) Building Tour. The Physical Plant and Site Survey consists of a building tour of the primary MTF and the outlying facilities as needed to validate, benchmark and document the current situation concentrating on:

- Mechanical & Electrical Rooms
- Equipment Condition (limited visual assessment)
- Communications Closets
- Roof
- Interior / Exterior
- Life Safety Code Compliance
- Project/Construction Areas
- Areas of concern based on the latest condition assessment, or the last FAAST visit

(4) Interviews. In addition to going over the checklist with the FM, the FAAST will need to interview other people such as those responsible for DMLSS data input, maintenance management, project execution, ISSA/MOA, Budget/Funding, and the possibly organizations outside the MTF, such as the DPW.

(5) Out Briefs. An out brief to the appropriate Command staff, and others, based on findings, is always required. It is the responsibility of the MTF to make sure that the appropriate command staff is available for the out brief. The FAAST will perform a detailed pre-brief to the FM followed by a summary brief to the C, LOG (or the FM’s immediate supervisor). Then, the Commander (or representative) is briefed on the overall condition of the facility, the FM organization and any deficiencies and/or advisories that need command emphasis and/or support.

(6) Final Reports

(a) The objective of the final report is to demonstrate the level of efficiency and effectiveness of the facility management organization. The report will identify what the organization does exceptionally well so the success may be shared with the rest of the AMEDD. The report will also indicate where the organization is not meeting USAMEDCOM standards and provide recommendations for improvement. The report consists of:

- Checklist with comments
- Executive summary
- Detailed report

- Photos with captions (as needed)
- A separate DA form 4965 for each deficiency (as needed)

(b) The timeline on developing, staffing and disseminating the final report is as follows:

- Within two (2) weeks of the completion of a visit, a comprehensive draft of the report, executive summary, checklist and photos will be provided to the ACSIE&FM and to the Subject Matter Experts (SMEs) at USAMEDCOM and HFPA for review and comments.
- The SMEs will then have one (1) week to complete the review and provide any comments back to the FAAST.
- Within 30 days of the completion of a visit, the FAAST will send out the final report (to include the executive summary, checklist, photos and 4965s as needed). If the FAAST visit is in conjunction with a formal review team such as a CLRT, OAP, etc, the final report will be sent to the OIC of the review team to be rolled into the official final report and then sent through channels to the MTF. If the FAAST visit is just an assistance visit, the final report will be sent directly to the FM. Copies of the final report will also be sent to the Facility Directors and SMEs.

(c) CLRT Finding Categories.

- Positive: Exceeds published standards and best business practices. Plans, programs or Ideas that qualify will be collected to share with the rest of the AMEDD.
- Advisory: Issue that is not in direct violation of a Code, Regulation or Policy, however requires immediate attention and remediation before it becomes a bigger issue and/or violation.
- Deficiency: Regulatory non-compliance or deviation from DA, USAMEDCOM or other established policy or regulation.
- Deficiency with potential liability: Regulatory non-compliance that could result in a potential liability such as non-accreditation, a monetary fine to either the organization or to the individual, or a potential legal claim.
- Outside Finding: A finding that is outside the control of the MTF.
- Repeat: Uncorrected finding (Advisory or Deficiency) identified in previous survey. Emphasis is brought to the fact that nothing has improved.

(d) CLRT Deficiency Tracking. A separate DA form 4965 detailing each deficiency as to what regulation, code or standard was in violation will be provided with the final report. Each 4965 will require a “Reply by Endorsement” from the MTF Commander to ensure the deficiency and the solution have command emphasis and support. The proposed solution will then be reviewed by the FAAST (or sent to the appropriate SME as needed) for concurrence. The MTF will be notified as to the concurrence or non-concurrence with the solution, and the deficiency and solution will be tracked. If repeat findings are observed during subsequent visits, the uncorrected finding will be noted as such.

8-14. TRAINING AND CAREER DEVELOPMENT

a. Purpose. Requirements of accreditation agencies, such as the Joint Commission, places significant emphasis on physical plant management and reinforce the need for a comprehensive facilities career enhancement and educational program.

b. Facility Management Responsibilities. Facility managers are responsible for the development and implementation on all aspects of training associated with their core responsibilities. Facility mangers are required to develop an annual training program for all personnel within the facility management branch. The program includes the nature of the training, whether the training is a regulatory requirement, the personnel assigned the training, the budgeted amount for the training, and the funding source. Training plans will be submitted to ACSIE&FM, Training Coordinator, as requested, on an annual basis, so that the Training Director can consolidate, budget, and schedule training events associated with the USAMEDCOM facility management corporate program for career enhancement.

c. ACSIE&FM Corporate Training Program. The USA USAMEDCOM ACSIE&FM Healthcare Facilities Branch provides assistance to MSCs, Regional, and MTF Facilities personnel in areas of facility management training, and educational career enhancement guidance, and policy determination. These areas are addressed through the Facilities Management Training Coordinator and the Facility Management Support Operations Center. The Healthcare Facilities Branch also offers technical guidance to MSCs, RMCs, and MTFs on O&M issues. The USAMEDCOM facility management corporate program for career enhancement analyses functional skills required for facility managers and FMB staff members, identifies primary training, continuing education, and developmental requirements, and develops staffing methodologies to maintain a high level of expertise in all USAMEDCOM facilities. Many functional skills sets and core competencies have been identified, and are being addressed in basic and advanced facility management courses. The objective of the USAMEDCOM facility management corporate program for career enhancement is to maintain a high competency rate for personnel within the facility management branches.

d. Training and Educational Programs.

(1) A DoD Tri-Service Medical Logistics Facilities Management training program has been established to cover the basis areas necessary to manage health care facilities. The purpose of the course is to provide a broad overview of DoD Medical facility management, and to insure that facilities are operated and maintained in accordance with applicable standards, such as Joint Commission, NFPA, OSHA, and EPA.

(2) The Facility Management Applied and Continuing Education course (FM-ACE) is offered through the USAMEDCOM ACSIE&FM Healthcare Facilities Branch on an annual basis. The course is an applied continuing education course. The purpose of this course is to provide facility managers with an advanced level of continuing education and state-of-art information on a wide range of facility issues, such as CMMS, reliability-based maintenance, and enhancement of customer service.

(3) The US. Army Corp of Engineers, Huntsville Division, offers many training courses related to facility management through the Proponent Sponsored Engineer Corps Training course. Facility managers can contact US. Army Corp of Engineers directly for application to courses.

(4) The USAF Material Command, School of Aerospace Medicine, Brooks AFB offers environmental courses in hazardous waste and emergency response, as well as other environmental courses. Also, Fort Sill, OK, Directorate of Environmental Quality offers a comprehensive program for environmental training.

(5) Some universities offer degree programs and short courses in facility management related subjects. At the time of this publication, a listing of these programs and courses is not available.

e. Facility Certification Courses.

(1) The American Hospital Association offers a Certified Health Care Facility Manager certification exam for qualified facility managers.

(2) Certification as a Facility Management Administrator is offered through BOMI Institute, Arnold, MD.

(3) Other facility management certification programs include the Certified Plant Maintenance Manager course through the Association for Facilities Engineers and the Certification in Health Facility Management, offered through the American Society of Healthcare Engineers (ASHE).

(4) Funding. Funding for training, education, and certification is the responsibility of the activity. In some cases, sustainment funds can be used for this purpose (refer to the latest USAMEDCOM Facility Information Bulletin for limitations).

f. Career Development

(1) Facility Management Training

(a) Facility Management Basic Course: The objective is to introduce Facility Managers to the basic overview of the Medical Facilities Management and to teach the Integrated Facility Life Cycle Management philosophy.
Location: Sheppard Air Force Base Wichita Falls, TX
Frequency: Four times per year. Duration: Three-week course

(b) Facility Management Applied and Continuing Education Course: The objective is to provide state of the art managerial and technical information for facility managers and facility directors.
Location: Varies Frequency: Annually Duration: One week

(c) Health Facility Planning Agency Post Graduate Short Course: The objective is to encourage AMEDD facilities community cross training and understanding as well as to enhance tri-service, interagency and civilian sector collaboration and synergy on execution processes and lessons learned to realize improved efficiencies and quality in all phases of health facility planning, design, and construction. Whenever practical, this symposium is held in conjunction with the ASHE Planning, Design, and Construction (PDC) Annual Conference.
Location: Varies. Frequency: Biannually Duration: One week

(d) Joint Services Facility Management Symposium: The objective is to provide gain critical insight into external organizations from all services and the DVA with the goal of becoming competitive and proficient managers of our healthcare infrastructure. Whenever practical, this symposium is held in conjunction with the ASHE Annual Conference and Technical Exhibition.
Location: Varies Frequency: Bi-Annually, sponsorship rotates between services
Duration: One Week

(e) ASHE Annual Conference and Technical Exhibition. The objective is to promote professional facility management through a recognized institution for health care facilities planning and sustainment, and to provide a means for structured professional development and facility management certification. ASHE provides up-to-the-date information on healthcare engineering.
Location: Varies Frequency: Annually Duration: Five Days

(f) Corps of Engineers, Huntsville, AL; Corps of Engineers DFWPROSPECT Courses: The objective is to provide facility management personnel at all levels with access to current courses and areas of interest that may not be available though the Corporate Career Enhancement Programs. See Purple Book for details.
Location: Varies Frequency: Varies Duration: Four hours

(g) Health Services Medical Materiel Management Course: The objective is to familiarize Logisticians with the organization and responsibilities of the Facility Management Branch in a Medical Treatment Facility.
Location: AMEDDC&S Frequency: Varies Duration: Two hours

(h) Intern Program. The objective is to supplement the attrition of USAMEDCOM's current inventory of professional facility managers and facility manager staff with newly trained staff. This program is operated through Madigan Army Medical Center Engineering Department. Applications are accepted on a bi-annual basis. Contact USAMEDCOM for detailed information.

CHAPTER 9. MEDICAL MATERIEL READINESS

9-1. AGENCIES SUPPORTING MEDICAL MATERIEL READINESS

a. **MACOM** (FORSCOM/USARPAC-EUSA/USAREUR): Sourcing Unit MACOMs will provide Unit funding and identify requirements for all medical (SRC 08) Units under their commands. MACOMs are responsible for supporting the required Contingency Plan and Operations Plan with Units that are adequately resourced to meet the warfighting combatant commander's requirements.

b. **USAMEDCOM/OTSG**: Programs, budgets, and executes central management of the Class VIII commodity, to include DA-funded, centrally managed programs (Army Pre-Position Stocks (APS), MCDM, Unit Deployment Packages (UDP), Installation Support Package(ISP)) and commercial business interaction. They also provide the doctrine, regulations, and policy for the medical force.

c. **Medical Research and Materiel Command (MRMC)**: Serves to integrate the testing, research, and materiel developer to identify the future medical threat, treatment requirements, and provide the standardized support for MTOE organizations. MRMC commands the USAMMA and the USAMMCE. These two USAMEDCOM materiel agencies provide assembly management and other centrally-managed support to CONUS and OCONUS theaters.

d. **The USAMMA**: Serves as the designated central medical materiel manager for USAMEDCOM/OTSG. The USAMMA manages strategic and operational medical materiel programs that support MTOE Units in all components. Serves as the materiel developer for Army standardized sets.

e. **Medical Logistics Support Team (MLST)**: Represents the USAMMA capability to handoff APS and other TSG contingency stocks to deploying units falling in on APS. The MLST operates under the operational control of the Army Materiel Command's (AMC's) Logistics Support Element and IAW the command surgeon guidance.

f. **Regional Medical Command (RMC)**: RMCs shift assets to support major mobilization requirements and provide resource management and contracting support to adequately support installation and deploying Unit requirements at the direction of USAMEDCOM/OTSG. RMC directs IMSA actions to support mobilization, deployment, and redeployment activities.

g. **Installation Medical Supply Activity (IMSA)** [Power Projection Platform {PPP}/Power Support Platform {PSP}]: Provide direct support for all standard and non-standard requests for medical materiel and equipment maintenance.

(1) IMSAs will provide the following support for deploying units:

(a) The M3PT tool will provide a listing of all MES/MMS that each installation supports by building a scenario for all supported units. Once the scenario is built, run the unit assemblage report to produce all NSNs that must be mapped to a SOS part number.

(b) Establish accounts for COMPO 1 units and map shortages to available sources of supply. Maintain customer files either, electronic or paper for COMPO 1 units. These files will contain unit contact information, a log detailing interactions between the unit and IMSA, and a listing of all authorized Class VIII items mapped to a source of supply part number with a record of this number built into the local MTF catalog.

(c) Maintain customer files either electronic or paper for COMPO 2/3 units. These files will contain unit contact information, a log detailing interactions between the unit and IMSA, and a listing of all authorized Class VIII items. The authorized Class VIII items are obtainable by running a unit assemblage listing in M3PT.

(2) Assist with storage and distribution of USAMEDCOM/OTSG centrally managed programs. Mobilization stations provide the support to deploy TO&E forces, fill deploying Units to meet Combatant Command (COCOM) force requirements, expansion of medical facilities and transition support to reserve elements to sustain the Mobilization station missions for continuing support through all phases of Army operations.

h. **Defense Supply Center Philadelphia (DSCP)**: Provide DLA/DoD interface for the Class VIII commodity. Provide commercial contracting and medical materiel support capability through the Defense Wide Working Capital Operating Fund.

i **Medical Logistics Management Center (MLMC)**: Provides an automated Single Integrated Medical Logistics Manager (SIMLM) support function for the COCOM (CINC is no longer an operational term) collecting and providing detailed medical materiel management functions allowing real-time commodity management and feedback to the force provider to ensure complete logistics coverage for a theater of operations.

j **AMEDDC&S**: Develops the doctrine, validates the current standards of care, and trains the medical logistician. Additionally, AMEDD&S Coordinates the training and modernization of the medical force with other Services and within the DA.

k. **The Directorate of Combat and Doctrine Development** (**DCDD**) serves as the combat developer, integrating doctrine and standardizing requirements in conjunction with the expressed capability requirements of the combat force.

9-2. BACKGROUND ON MEDICAL MATERIEL READINESS

a. Class VIII materiel support for Army Units is divided into several categories:

(1) **Non-Unit Assemblage (UA) Materiel** (clinician or mission specific, non-standardized)

(2) **Non-Centrally Managed UA Materiel** (Unit funded, centrally standardized)

(3) **Centrally Managed** (the USAMMA and DSCP-managed, standardized)

(4) **Medical Chemical, Biological, Radiological, and Nuclear (CBRN) Defense Materiel (MCDM)**(OTSG-owned, USAMEDCOM/USAMMA-Managed)

(5) **Army Pre-Positioned Stocks** (APS – geographically distributed, DA-owned, USAMMA-managed)

(6) **Army Emergency First Responder Program** (AEFRP) and the joint **Installation Protection Program** (IPP) (USAMEDCOM owned and managed)

(7) **Radioprotectants** (DoD owned)

b. The USAMMA is responsible for the initial fielding of the MMS and MESs that comprise a Unit Basic Load (UBL). These SKOs are currently fielded as outlined in *AR 40-61*. The IMSA is the source of supply to fill Unit-generated shortages (consumed items, Unit assemblage updates, expired items, and field losses) for all Units. In order to maintain readiness, all supplies must be on hand, on order, or part of a pre-arranged agreement where previously identified items may be obtained through PVs or other contract sources. Based upon unit deployment timelines, it is the unit's responsibility to maintain their basic load, unless covered by a centrally managed program. Units must submit funded requisitions to procure these items. The IMSA will map requirements to ensure that there is a viable acquisition tool in place to procure these items. The Unit is required to make annual coordination with the IMSA to identify shortages and coordinate sources of supply.

c. All medical Units must coordinate their requirements for medical materiel to their supporting IMSAs annually. Reserve Units will maintain only the non-expendable and durable components of their UBL. The IMSA will be the source of supply to acquire the Class VIII expendable UBL items to support Reserve Component (RC) Units upon mobilization. The IMSA will match these requirements to a source of supply to ensure rapid acquisition. All Units will validate that the acquisition timeline supports their wartime mobilization mission.

d. Managed Materiel

(1) Non Centrally Managed: Division And Below (DAB) Units must maintain their basic loads and fill Unit generated shortages, Unit Assemblage (UA) updates, and mission-specific items. Commanders will maintain UAs per guidance in this SB 8-75-11, Chapter 10. The AMEDD does not centrally manage materiel for active component divisional Units. DAB medical units are expected to deploy with their entire Class VIII UBL.

(2) Centrally Managed: For rapid deployment/contingencies, however, DA Deputy Chief of Staff Operations may identify and direct that a DAB Unit will be supported by centrally managed Brigade sets from APS (reference *SB 8-75-S7*). These directions will be published in the applicable Operations Order (OPORD).

e. The USAMMA centrally manages Class VIII materiel for early deploying Active and Reserve Medical Units at the level above Division. This materiel serves as initial deployment medical UBL for deploying Units. The materiel contained in this program is identified in the *SB 8-75-S7*. The USAMMA, USAMEDCOM, and the deploying Unit will coordinate for acquisition and hand off of class VIII materiel in a contingency. The MLST is the medical materiel hand-off team that is an integral part of the Army Materiel Command Logistics Support Element (LSE). The MLST will hand off Class VIII Unit Deployment Packages (UDP) and APS as directed by the USAMMA in coordinated effort with the deploying Unit.

9-3. COMMON READINESS MATERIEL ITEMS

CTA 8-100 is the source for all deployable Unit common medical items (Chap Stick™, foot powder, first-aid kits, etc.). These items are requested through the supporting IMSA. CTA 8-100 provides a basic guideline for the quantity of items to order for a given Unit. Unit supply personnel order these items using OMA funds.

a. Combat Lifesaver (CLS) Bags/Training: These are service-regulated items. They are ordered through the supporting IMSA with a justification memorandum attached detailing the personnel who will receive the MES, and their current training qualification. Only currently certified CLS personnel will receive the MES. Units will store the controlled components of CLS bags to prevent misuse IAW *AR 190-51* (Unit safe, with designated/controlled access; inventoried quarterly). MES CLS is accounted for as a durable item and hand receipted to the user level.

b. Patient Movement Items (PMI): PMIs are initially issued with SKOs to Units identified during contingency operations. Replenishments are done by line-item requisition or direct exchange on a one-for-one basis with other Units during patient transfer. PMIs are service-certified for Air-Worthiness Standards based on Service specific airframes and intended to be used on the service associated evacuation platforms. Hand receipted durable items are accounted for by item, not serial number or other marking method. Non-expendables are controlled by serial number except where transferred for patient evacuation (ambulance exchange).

c. Moulage: Casualty simulation sets, or moulage sets, are CTA-authorized items. Typically, the supporting installation Training Aid Support Center will maintain sets for use. Otherwise, Units will order the sets according to *CTA 8-100* through their servicing IMSA. The sets are durable items and replenished by line item requisition.

9-4. LEVELS OF SUPPORT FOR MEDICAL MATERIEL READINESS

a. Division Units: For Units in Divisions, Regiments, and Separate Brigades, medical materiel support is provided by the Division/Brigade/Regiment Surgeon's Office via either the Division Medical Operations Center/DMSO (legacy system) or the Division Materiel Management Center (DMMC) Medical Supply section (current system). Medical materiel in combat units is highly standardized, decentralized (controlled and managed by operational funds at the lowest level), and sustained by the owning Unit.

(1) Fielding of UBL: Units are fielded their MESs and other authorized medical items by the USAMMA. The USAMMA Fielding Team conducts scheduled fieldings of Unit MES and other centrally managed SKOs within the Division. The USAMMA provides a one-time fielding for the SKO and upon completion of fielding, transfers accountability to the Unit to maintain and provide status on the SKO through command channels.

(2) Unit shortages/Sustainment of UBL: Units are funded and expected to maintain their sets to the highest level of fill to ensure readiness of the sets. Initial fielding shortages are filled by follow on ship short packages or direct funding to the Unit to order locally to fill any SKO shortages. Sustainment of the sets is the responsibility of the Unit commander and Division Surgeon (DS). Units will have materiel available within 72 hours. This means that materiel will either be accounted for as on hand, on order with a valid status, or directly available from the source of supply (for unfunded requirements). Units will validate annually through their source of supply (DMSO, DMMC, and IMSA) the availability of all materiel requirements that are currently not on hand. Sets with specialty items (Chemical Patient Decontamination) or short shelf-life items (Field Laboratory) will be closely managed to avoid expiration of vital components.

(3) The MCDM:

(a) Deployable Force Package assets of MCDM are centrally managed to support initial issue Individual Service Member requirements for Army personnel deploying to high threat areas. See SB-8-75-S7 for details on management and release of this materiel.

(b) MES, Chemical Agent Patient Trmt, LIN: M23673 Potency and Dated (P&D) items are centrally managed for early deploying units plus forward deployed, See *SB-8-75-S7* for detail on management and release of this materiel.

(4) Mobilization/deployment instructions: Upon deployment or mobilization notification, Units will validate their deployment Class VIII DODAAC and order all shortages from the supporting IMSA/SSA for receipt and packaging. Unit UBL is typically considered To Accompany Troops (TAT) and loaded with other Unit equipment. It is essential that these Units deploy with 100 percent of the required capability as sustainment is based upon that planning assumption.

b. Levels Above Division: For Corps and higher level units, the typical structure of a Medical Brigade or Command will have medical logistics elements specifically designated to support the medical materiel and equipment requirements for those Units. Unit medical supply personnel will integrate via automated systems into the MEDLOG Company Combat Automated Support Server - Medical system to order shortages and validate status. Units will order and maintain their basic load except where covered by a centrally managed program as discussed below. Where Units are not supported in garrison by their MEDLOG Company, they will maintain active accounts with their IMSA for all deployment and training Class VIII requirements.

(1) Fielding of UBL: the process for these Units is essentially the same as Divisional Units; the key difference for selected early deploying (D-Day through D+30) EAD Units is the coverage by UDP for various Unit types (see *SB 8-75-S7*). For Units covered by UDP, only select materiel is fielded to accompany the non-expendable and durable ARC N and D components of Medical SKOs. Potency and Dated items between 1 and 60 months of shelf life are centrally managed in the UDPs associated with those Units, and the Units are not required to maintain or sustain those lines. For Units not covered by a UDP, the requirement for those Units is no different from Divisional Units – maintain sets to 100 percent on hand, on order, or validated as available from the local source of supply.

(2) Unit shortages/Sustainment of UBL: Units covered by UDP will maintain only designated “non UDP” covered lines at 100 percent fill. Units not covered by UDP will maintain highest level of fill funded and validate all unfunded requirements through source of supply to ensure acquisition capability subsequent to deployment funding supplements or project codes.

(3) MCDM: Units will draw/issue/turn-in their MCDM in the same manner as Divisional Units. Hospitals with a DS support requirement will also order and distribute MCDM in accordance with their DS support instructions. (For example, a CSH that supports three (3) Forward Surgical Teams (FSTs), provides MCDM and other supply support).

(4) Mobilization/deployment instructions: Per *SB 8-75-S7*, Units supported by UDP will maintain current contact information with the USAMMA and support fielding and issue

plans for that materiel. Except for early deploying Units falling in on APS (UDP and other items), Units will plan and coordinate the transportation of Class VIII through their ITO. The level above Division medical units is typically more diverse than Divisional Units, and acquisition strategies to cover the greater range of requirements must occur annually between the IMSA and the unit.

(5) Redeployment: Units redeploying will either conduct a transfer of centrally-managed assets to the relieving Unit (in place) or turn in the centrally-managed assets to the supporting Medical Logistics Unit for return to centrally managed programs. Retention of those centrally managed assets requires further accountability by those Units until they turn-in those items.

c. MTOE Hospitals (Active Component): Medical Force 2000 and Medical Reengineering Initiative hospitals represent the Level 3 and 4 [North Atlantic Treaty Organization (NATO) Role 3] requirements for surgical stabilization and intensive care management of casualties. They also provide direct support for subordinate assigned and attached units, and Area Support for medical logistics when not co-located with MEDLOG Detachments or Companies.

(1) Fielding of UBL: The USAMMA provides centralized fielding and modernization of MTOE hospitals. Units are fielded to the current Program Objective Memorandum budget for that year, typically resulting in a 90 percent fill of non-UDP covered MMS and MESs. Additionally, APS cover early strategic hospitalization requirements due to the large transportation requirement required to move Hospitals.

(2) Unit shortages/Sustainment of UBL: Units are expected to maintain the fielded level of fill for their sets regardless of their designation as an early deployer (required to fall in on APS).

(3) MCDM: Units will draw/issue/turn-in their MCDM in the same manner as Divisional Units. Hospitals with a DS support requirement will order and distribute MCDM in accordance with their DS support instructions. (For example, a CSH that supports three FSTs will provide MCDM and other supply support.)

(4) Mobilization/ deployment instructions: Upon confirmation of deployment orders, the designated Unit will either receive augmentation in the form of UDP at mobilization station (assisted by the USAMMA Materiel Fielding Team {MFT}) if they are deploying with the first thirty (30 days) or (for early deploying Units) move via airlift (TAT only) and fall in on APS (assisted by the USAMMA MLST).

d. MTOE Hospitals (Reserve Component)

(1) Fielding of Mission Essential Equipment Training (MEET) sets: MEET sets are the non-expendable and durable components of selected MMS modules that make up a reserve hospital. MEET sets allow reserve hospital commanders the opportunity to perform the major tasks of setting up (complexing) hospitals and establishing the physical layout without buying and maintaining a vast amount of potency dated or maintainable items. MEET sets are fielded by the USAMMA to reserve component medical hospitals. Units conducting normal Reserve training drill or annual training are expected to purchase expendable components with training funds to make the MEET sets capable of supporting training objectives.

(2) Reserve Component Hospital Decrement (RCHD) Program: RCHD augments the MEET sets to fill out the remaining requirements to make the hospital fully operational for mobilization and deployment. RCHD assets are stored at Sierra Army Depot and fielded to the Unit at the mobilization station. The Unit and the USAMMA MFT field RCHD.

(3) MCDM: Units will draw/issue/turn-in their MCDM in the same manner as Divisional Units. Hospitals with DS requirements will support in the same manner as Active MTOE hospitals.

(4) Mobilization/deployment instructions: Upon receipt of an alert order, Unit Reserve Support Center liaisons should initiate contact with the OTSG to begin the process of identifying the Unit RCHD requirements to augment MEET sets. Reserve Units, deploying after D+30, are expected to bring their full equipment load to the mobilization station, to further augment with RCHD to the full capacity of their respective MTOE strength. Units will also receive any supporting UDPs at this time and flow with full equipment. Selected Reserve Units may fall in on active component sets that were released by Active APS supported hospitals.

(5) Re-deployment: RC Units will redeploy with their equipment. Federal Law requires that RC Units maintain accountability within their component – meaning that Active

Component Units cannot fall in on RC equipment unless they exchange equipment or receive exception consideration from DA G-3/G-4 via sourcing MACOM FORSCOM, USARPAC/EUSA, and USAREUR]. Upon redeployment, Units will return RCHD elements to the RCHD program with assistance from the USAMMA MLST or MFT.

e. All Units

(1) COMPO 1 Units will establish, at a minimum, an account with valid Assumption of Command orders and current DA 1687-Delegation of Authority Signature Card. Units will provide a copy of their Class VIII shortages.

(2) COMPO 2/3 units will provide valid unit contact information. This information should include at a minimum, unit name, Commander's name, address, phone number, email address of medical supply POC. This information must be updated biennially or upon unit relocation.

(3) Units are expected to maintain the highest level of readiness for which they are funded. Units are expected to deploy at greater than 90 percent of MTOE required strength for equipment in order to be certified by an installation commander.

(4) Units will receive applicable centrally managed materiel (typically MCDM) upon receipt of valid deployment orders or by Surgeon General directed and approved release (contingency support requirements).

9-5. MEDICAL CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR (CBRN) DEFENSE MATERIEL (MCDM)

MCDM is centrally managed by the OTSG and executed by the USAMMA. See DA *SB-8-75-S7* for details on management and release of this materiel.

9-6. ARMY EMERGENCY FIRST RESPONDER PROGRAM AND THE INSTALLATION PROTECTION PROGRAM

a. The Army Emergency First Responder Program (AEFRP) and the joint Installation Protection Program (IPP) provide CBRN pharmaceutical countermeasures (CPCs) to protect and treat emergency first responders and mission critical personnel who are exposed to CBRN agents, as a result of a CBRN incident on a installation.

b. Procedures for managing this materiel are still being developed. Draft guidance has been sent to the RMC. Final procedures will be published as an addendum in a future SB.

9-7. RADIOPROTECTANTS

a. The Radioprotectants are pharmaceutical countermeasures for use after an nuclear incident.

b. Procedures for managing this materiel are still being developed. Final procedures will be published as an addendum in a future SB.

9-8. MEDICAL MATERIEL READINESS SPECIAL CONSIDERATIONS

These categories of items require special attention and management beyond what has been addressed previously. Additionally, these are specific readiness items that affect Unit deployments and sustainment due to acquisition restrictions and distribution controls that are not regulated by USAMEDCOM/OTSG policies. (Controlled substances are discussed in other chapters of *AR 40-61* and *AR 190-51*.)

a. Lab Reagents: Lab reagents are characterized by three important factors:

Limited Shelf Life Temperature Regulation Limited Commercial Production

As such, laboratory reagents are typically acquired by either local purchase or utilizing DSCP E-CAT web ordering tool from a vendor. Lab reagents may have long lead times for acquisition utilizing standard ordering procedures. The expected means of acquiring these items is through utilization of the DSCP ESOC for deploying and deployed medical Units requiring lab reagent support.

b. Cold Chain management: TSMP require specific transportation controls to ensure that they maintain their viability between source and patient delivery. For items requiring cold chain management functions, the supporting SIMLM or the USAMMA Distribution Operations Center (under the USAMMA Force Sustainment Directorate) will support all packing and transportation instructions to ensure that adequate cold chain management measures are performed. Suspect medical materiel will be segregated and reported using Medical/Dental Product Quality Deficiency Report (M/DPQDR)--formerly SF380--Medical Complaint procedures to prevent patient injury or death.

c. Hazardous Materiel (HAZMAT): HAZMAT will be transported according to DOT and DoD requirements for safe movement. HAZMAT will be stored according to specific storage instructions for each item and category of HAZMAT. Additionally, applicable MSDS and other OSHA requirements will accompany all HAZMAT items for storage, shipment, and usage. HAZMAT is packed and shipped separate from other supplies and equipment and specific instructions on handling will be clearly marked on each package or container. Personnel who handle HAZMAT will be certified according to MACOM and OSHA requirements before transporting, packing, or handling HAZMAT items.

9-9. OCONUS MEDICAL LOGISTICS SUPPORT

a. **USAMMCE**: This TDA organization serves as the SIMLM for European Command, Africa, and South West Asia (SWA). Provides medical materiel management, depot level medical maintenance, and multi-vision optical fabrication for all services.

b. **16th MEDLOG BN**: This TDA-augmented MTOE organization serves as the SIMLM for Korea. Provides medical materiel management, GS medical maintenance, and multi-vision optical fabrication for all services on the Korean peninsula.

c. **226 MEDLOG BN**: Provides Medical Logistics support to European units and ongoing contingency operations throughout the European theater.

9-10. SOLDIER READINESS PROCESSING (SRP)

a. The USAMEDCOM responsibility for SRP/Predeployment Processing (PDP) is to provide screening checks for medical, dental, and visual readiness. Personnel are given updated medical examinations, dental examinations, vaccinations, eye examinations and medical appointments to ensure that all necessary standards of fitness are achieved prior to deployment. IMSAs are funded to provide those basic services and are coordinated by the hosting installation for Unit SRP functions.

b. Supplies are ordered from the supporting IMSA and paid for by that activity for all SRP requirements.

(1) Theater prophylactic requirements are defined by the sourcing and requiring commands. Vaccinations and other forms of prophylaxis are distributed prior to deployment and managed by the Unit surgeon for continued treatment upon deployment. Personnel medical records are updated during SRP to show initial vaccination and issue of prophylactic medicines.

(2) Optical devices will be prescribed and issued prior to deployment of personnel from the Mobilization station. The basic requirement will be:

One pair standard eyewear
One protective mask insert
One combat eye protection insert and
One Land Operations (LO) frame for those personnel who meet the vision readiness requirement for corrective eyewear as determined by competent medical authority.

CHAPTER 10. PROCEDURES FOR MANAGEMENT OF MEDICAL ASSEMBLAGES

10-1. ACCOUNTING, MANAGEMENT, AND UPDATE OF MEDICAL ASSEMBLAGES

a. Accounting and managing for components of Medical Assemblages.

(1) MTOE commander responsibilities.

(a) Establish and maintain property accounting records on each authorized non-expendable item using the manual property accounting procedures, or an approved DA automated property accounting system (see *DA PAM 710-2-1*).

(b) Establish a viable Quality Control program for all dated items.

(c) Under the inventory provisions of *AR 710-2* and *DA PAM 710-2-1*, manage expendable and durable ARC "X" or "D" components of MESs on hand-receipts {(Supply Catalog (SC) *6545-8 Series*}, or as part of the Unit Assemblage Listing (UAL). These components are listed in the SC or UAL to identify authorized quantities. When using the SC and/or the UAL, use the most recent document.

(d) Medical items are classified as durable because users do not expend them in the first use. Unless there is evidence of pilferage, treat the loss of these items as if they were expendable. Commanders are not required to account for durable losses from MES/MMS under the provisions of *AR 735-5*, paragraph 14-25, unless the commander suspects negligence, theft, or willful misconduct.

(e) Commanders will inventory MES components against the fielded UAL at least every six months (12 months in RC) to measure readiness. Units may perform this inventory in conjunction with other required inventories as long as it meets the requirements stated above.

1) Commanders of Medical Reengineering Initiative Hospitals with equipment in long-term storage under the AMEDD Hospital Optimization Standardization Program (HOSP) will follow procedures outlined by their MACOM.

2) Items listed in the Section II of the fielded UAL and in Section III of the SC 6545-8 series are Associated Support Items of Equipment (ASIOE) end items dedicated to the operation and maintenance of the medical assemblage. The listing is for information purposes only and does not constitute an additional authorization. The unit's MTOE/TDA reflects total authorizations.

(f) Record and account for inventories as follows:

1) The approved system for management of all medical equipment/materiel set inventory is the Medical Materiel Mobilization Planning Tool (M3PT). M3PT is located at www.mods.army.mil.

2) Medical equipment/materiel set management requirements for all units are as follows:

a) Request access to M3PT at www.mods.army.mil Commanders will designate individuals within the unit for write access to M3PT. Write access allows users to input/edit inventory of a unit.

b) Unit personnel will conduct an inventory of their fielded MES/MMS using component listings available in M3PT. Units must select the version of the MES/MMS that they were fielded. If fielded MES/MMS version is not available it can be built in the set tool module of M3PT and downloaded into the unit assemblage management tool (UAMT) module of M3PT.

c) Unit authorized personnel will input the inventory results for each MES/MMS into the UAMT Inventory results include quality assurance/control information and medical maintenance for items as required by M3PT in the special handling codes column.

d) Upon completion of inventory input, unit will use the *AR 220-1* percentage of fill calculation generated by M3PT to determine the on hand status of each MES. Refer to *AR-220-1* chapter 5, paragraph 5-5, for evaluating component part availability.

3) MTOE hospitals and division/brigade/regimental MSOs will manage ASL items in anticipation of a re-supply mission.

a) Establish a DA form 1296 for each item for which you expect demands. Use the component listing of the authorized MES and *CTA 8-100* as a guide. Detailed instructions for using stock accounting records are in *DA PAM 710-2-2*. Use these forms, with

support records, to informally manage supply activities upon mobilization. Advance preparation will enhance your operational readiness upon mobilization or deployment.

b) Establish a DA form 4998-R for each medical item with a shelf-life and for which you expect demands. This form will help you manage required QC actions.

b. Medical Assemblage Updates: Non-hospital commander responsibilities.

(1) Maintain your assemblages in the UAL configuration based on the set NSN you were fielded.

(2) There is no requirement to purchase OMA-funded components for cyclic MES changes. Units will move forward to the new UAL configuration, and corresponding NSN, when fielded by USAMMA.

(3) Units are not precluded from selectively upgrading OMA-funded set components to the most current configuration if unit funding is available. If commanders selectively upgrade set components, they will inform USAMMA of any changes.

USAMMA
ATTN: MCMR-MMO-S
1423 Sultan Dr., Suite 100
Fort Detrick MD 21702-5001
DSN 343-7161 or COMM 301-619-7161

or

Customer Relations Management (CRM) Office
DSN 343-4301/4316 or Commercial 301-619-4301/4316
E-Mail: USAMMACRM@amedd.army.mil

(4) Execute an NSN change IAW *DA PAM 710-2-1* to property-accountable records for sets the unit fully upgraded to the new UAL configuration.

c. Commanders of Deployable Medical Systems (DEPMEDS) equipped units will inventory the medical assemblage against the UAL (Assemblage Control Number (ACN)/Build Directive Number (BDN) – specific) that is provided when fielded to the unit until authorized for update by the USAMMA.

10-2. PROCEDURES FOR LOAN OF MTOE MATERIEL (EQUIPMENT) IN SUPPORT OF PROJECTS AT HEALTHCARE ACTIVITIES (HCAS)

a. For guidelines for temporary loan of MTOE Assemblages/Equipment to HCAs/TDA facilities see *AR 700-131*, para 2-2 and applicable local command guidelines.

b. Procedures for loan of medical equipment to units from USAMMA

(1) Policy. *AR 700-131, Loan, Lease, and Donation of Army Materiel*, sets forth the policies and procedures for loan of Army materiel to both Department of Defense (DOD) and non-DOD activities of the Federal Government and loan, lease or donation of materiel to non-Federal civilian activities and agencies. It outlines when loans, leases, or donations of Army materiel can be made.

(2) Responsibility. The Surgeon General is responsible for loans of medical materiel IAW, *AR 700-131* (Table 2-1). The Commander, USAMMA, is responsible for approving requests for loan or lease of principal medical end items IAW, *AR 700-131* (Table 2-1) and *AR 40-61*, *Medical Logistics Policies*. The Commander, USAMMA, may approve principal medical end items in wholesale level inventories for loan unless the loan would at any time interfere with issue against the Army Resourcing Priority Listing. In such cases, requests will be forwarded for approval to

Office of The Surgeon General (OTSG)
ATTN: DASG-LOZ,
5109 Leesburg Pike,
Falls Church VA 22041-3258

The Commander, USAMMA, may approve minor medical materiel in wholesale inventories for loan.

(3) Types of equipment available for loan. Medical materiel available for loan include, but are not limited to, Computer Tomography (CT) Scanners, Deployable Medical Systems (DEPMEDS), ISO Shelters, Non-Medical ASIOE, Environmental Control Units, and Heaters.

(4) Duration of loan agreements. Loan agreements with USAMMA are typically one year in length; however, agreements for periods of less than one year, but greater than six months are also available.

(5) Submitting requests for loan of equipment. Requests for loans of equipment will be approved or disapproved based on the purpose, duration of the loan, and consideration of the following factors that can take precedence over any loan or lease:

(a) Military requirements and priorities.
(b) Stocks and programmed Army requirements.
(c) Type classification with pending changes.
(d) Minimum diversion of Army stocks.
(e) Adequacy of the borrower's resources.
(f) Availability of alternative sources such as commercial leases.
(g) Eligibility of the recipient.

Units must complete DA Form 4881-6-R, using DA Form 4881-2-R if more than one item is required and forward with a memorandum of justification, signed by a Colonel (O-6 or higher) through command channels to Headquarters, US Army Medical Command (USAMEDCOM) for approval. If a MFT is required to field the materiel, the requesting unit is responsible for travel and per diem expenses (military and civilian) for the initial set up and their return upon termination of the loan agreement. In addition, the requesting unit is responsible for packing, crating, handling, and shipping of materiel from supply source to destination and return. This includes port handling and off loading, if applicable. The requesting unit must pay for the refurbishment cost to bring the equipment back to condition code "B".

(6) Points of contact

(a) The mailing address and point of contact at USAMEDCOM is:
Department Of The Army
Headquarters, US Army Medical Command
ATTN: MCLO
2050 Worth Road
Fort Sam Houston TX 78234-6000
POC DSN: 471-7066

(b) The mailing address and point of contact at USAMMA is:
US Army Medical Materiel Agency
ATTN: MCMR-MMO-S
1423 Sultan Drive, Suite 100
Fort Detrick MD 21702-5001
POC DSN: 343-4448

CHAPTER 11. OPTICAL FABRICATION

11-1. OPTICAL FABRICATION AUTHORITY AND OVERVIEW

Optical fabrication has become a consolidated effort within DoD. In response to this consolidation, the Optical Fabrication Enterprise (OFE) was formed, with the Navy Surgeon General designated responsible for management of the OFE.

a. The OFE was created to manage the DoD's optical fabrication assets, and meet optical fabrication requirements of all services. The OFE charter includes all DHP supported laboratories.

b. The Navy Surgeon General in turn designated the Commander of Naval Ophthalmic Support and Training Activity (NOSTRA) to provide day-to-day oversight of the enterprise. To manage and maintain DoD optical fabrication, an Optical Fabrication Advisory Board (OFAB) was established.

c. The OFAB acts as the primary advisor to the OFE. The OFAB operates with a combined staff consisting of members from the Army, Air Force, Navy and one representative from DoD's Secretariat. The chairman of the OFAB is either the US Army Medical Command's Chief of Staff for Logistics or Assistant Chief.

d. The Army Optical Fabrication Laboratories (OFL) and Units fabricate prescription eyewear that includes spectacles, protective mask inserts, Military Combat Eye Protection inserts and similar ocular devices for eligible personnel under the guidance of:

- *AR 40-63*
- *NAVUSAMEDCOMINST 6810.1*
- *AFR 167-3*

e. This chapter identifies requirements used for the management of Army optical fabrication laboratories located at both Modified TDA (MTDA) and MTOE activities/Units.

11-2. OPTICAL FABRICATION ENTERPRISE REPORT

The Consolidated Optical Fabrication Enterprise Report provides data on optical devices fabricated by optical laboratories. It is used in:

- Planning mobilizations
- Preparing budgets
- Assigning opticians (68Hs)
- Analyzing inter-service support
- Utilization of manpower
- Analyzing cost/production efficiency

11-3. COMPLETING OPTICAL FABRICATION ENTERPRISE REPORT WORKSHEETS

a. General information and instructions for completing and submitting the OFE Report worksheets are available from the USAMEDCOM, ACSLOG, Operations Management Division, or NOSTRA.

b. The report is located on **https://www.medlogspt.army.mil** and is a fully integrated, online, data-reporting tool. The OFE Optical Fabrication Web-tool consists of four reports with content-sensitive instructions integrated within each metric. The reports metrics are titled: Production, Financial, Staff, and Performance. These on-line reports have been developed to capture data and additional information required by OFE and USAMEDCOM.

c. To access from the web:

Use **https://www.medlogspt.army.mil**; personnel must register on the site then contact USAMEDCOM ACSLOG, Operations Management Division for access to the OFE optical Fabrication web-tool.

Once verification and user-level is determined, access will be granted to the OFE Web-tool.

- ❖ Clicking on the OFE button (top menu) will bring you to the OFE page.
- ❖ Afterwards, click on the left display menu bar click on Programs.
- ❖ Thereafter, click on the top display areas for the various reports metrics titled, Production, Financial, Staff, and Performance.
- ❖ Once input is made, click on submit. The information will be stored on an archived retrievable database.

d. All MTDA optical laboratories and 16th Med Log Bn will:

(1) Submit a monthly, consolidated, optical fabrication enterprise report located on https://www.medlogspt.army.mil .

(2) The submitted report will be staffed/reviewed through command channels to the appropriate RMC or Command Surgeons. The report will then be reviewed by USAMEDCOM NLT the fifth of each month.

(3) If additional information or guidance is required on optical issues, please contact:

USAMEDCOM
ATTN: MCLO
2050 Worth Road
Fort Sam Houston TX 78234-6008

CHAPTER 12. DOD PATIENT MOVEMENT ITEMS (PMI)

12-1. PATIENT-MOVEMENT ITEMS (PMI) EQUIPMENT

a. **DEFINITION:** PMI is the specific medical equipment and durable supplies that must be available to support patient transport. The PMI program consists of designated medical equipment assets (including the consumable supplies needed for their proper use) and associated durable supplies necessary for patient transport. The DOD PMI Program inventory is contained in the allowance standard (AS) 887P series. Examples of standardized PMI include: Zoll Defibrillators, Ventilator Impact 754M, Controller Ivac Alaris MedSystem III, Suction Impact 326M, Monitor Propaq 206EL, Pulse Oximeter BCI 3303 and Oxygen Analyzer MiniOX 3000. The mission of the PMI system is to support patients' in-transit, to exchange in-kind PMI without degrading medical capabilities, and to provide prompt recycling of PMI. It is the originating MTF's responsibility to provide the PMI required to support the patient during movement. PMI accompanies a patient throughout the chain of movement, from the originating MTF to the destination MTF, whether it is an intra-theater or inter-theater transfer. Planners must ensure that PMI is available at the correct location and ready for use.

b. **AIR-WORTHINESS RELEASE (AWR)**: AWR has been approved for the standardized PMI used during evacuation of patients on military aircraft. Requests to add items to the AWR list should be sent to the:

Commandant, AMEDDC&S
ATTN: HSMC-FC
Fort Sam Houston, TX 78234,

IAW *AR 40-61*, Section 3-22, paragraph 6d, and coordinated with HQ AMC/SGXL to include fixed wing air worthiness approval.

c. **PATIENT MOVEMENT ITEM TRACKING SYSTEM (PMITS)**: PMITS is a software system used to keep track of moveable medical assets such as PMI. It was developed by a commercial vendor and managed by the Program Management Office Defense Medical Logistics Standard System (DMLSS). PMITS keeps track of equipment by collecting scans and sharing the information with other PMITS users, thereby making the data available to those managing re-supply. The software is installed on a laptop computer and uses a barcode scanner to load the label readings into a network providing the PMI type, model and serial number of the asset. The PMITS laptop maintains the database that is refreshed every twenty-four hours. The PMITS database contains information to identify ownership, and the movement history of all scanned and tracked items. There are special printers at the PMI Centers available to create bar code labels to place on equipment. Not all units or MTFs will have a PMITS system. Those who do not have PMITS, will need to track the PMI manually, as described below in para. 12-2., Procedures For Processing PMI.

12-2. PROCEDURES FOR PROCESSING PMI

a. Theater Units: Combatant Commander. Intra-theater movement of PMI is the responsibility of the theater commander. Theater policy for PMI will be established and distributed to the applicable units, as required.

b. CONUS MTFS

(1) As patients are evacuated back to MTFs closer to home station, their care is the first priority. Once they are stabilized and transitioned to a ward at the MTF, the PMI is no longer needed for those patients. The PMI will be recycled, and returned to medical logistics and in turn to the nearest PMI Center.

(2) The three divisions within the MTF that coordinate the patient's movement with PMI are; Patient Administrative Division (PAD), the Emergency Division (ED) and the Logistics Division (LOG).

(a) The Chief of PAD will ensure that the timely notification of all inbound and outbound patients is provided to ED and LOG. PAD will also provide them a copy of the Patient Movement Request (PMR).

(b) The Chief of ED will manage the patients and the PMI that accompanies them. Once the PMI is no longer needed for the patients, PAD will notify LOG that the PMI is available for pick up.

(c) The Chief of LOG will ensure that PMI is picked up, as required, from ED and delivered to the nearest PMI Center location. Managing PMI assets includes tracking each item by using manual transfer documents or scanning the items using PMITS where available.

(3) The Transportation Management Office can assist in determining which AFB is closest. Transportation Account Code (TAC) (F144) is authorized to fund military air. TAC (A1LD) is authorized to fund routine ground transportation. PMI Center Shipping Locations are:

(a) 89th Medical Group/SGSL PMI Center
3244 Tennessee Ave
Andrews Air Force Base, MD 20762-5184
DSN 857-7956

(b) 375th Medical Group/SGSL PMI Center
120 South Adams Street, Bldg 4020
Scott AFB, IL 62225-5300
DSN 576-1173

(c) 60th Medical Support Squadron/SGSL PMI Center
101 Bodin Circle, Bldg 795
Travis AFB, CA 94535-1800
DSN 796-3755

(d) 435th Medical Group/SGSL PMI Center
PMI Center Ramstein
Unit 3215
APO AE 09094-3215
DSN 314-479-2437

(e) Air Force Medical Support Agency (AFMSA/SGSLW)
Mark For: Patient Movement Items (PMI)
601 Davy Crockett Drive, Bldg 1534
Kelly USA, TX 78226-1885
DSN 945-6061

(f) 374th Medical Support Squadron/SGSL, PMI Center
Yokota Air Base JA
Building 4145, Unit 5225
APO AP 96328-5225
DSN 315-225-4932

12-3. REFERENCES:

For additional information refer to the below listed documents or contact ACSLOG representatives at 210 221 6044/6435

a. *Army Regulation 40-61, Chapter 5*, *Medical Logistics Policies and Procedures*, dated 25 January 1995.

b. *Air Force Instruction (AFI) 41-209, Chapter 8*, Patient Movement Items (PMI) dated 10 March 2004

c. *Joint Pub 4-02*, Doctrine for Health Service Support in Joint Operations dated 30 July 2001.

d. *Joint Pub 4-02.1*, Joint Tactics, Techniques, and Procedures for Health Service Logistics Support in Joint Operations dated 6 October 1997.

e. *Joint Pub 4-02.2*, Joint Tactics, Techniques and Procedures for Patient Movement in Joint Operations dated 30 December 1996.

f. *FM 4-02.1*, Combat Health Logistics, Appendix F, Patient Movement Items dated 28 September 2001.

12-4. BAR CODING METHODOLOGY AND CODES

PMI will be identified and tracked using a bar code system. The item identification code has 14 positions to identify the type of item and model:
(10 Aug 06, check for latest version at: https://private.amc.af.mil/sg/sgsl/sgslpmi)

a. Positions 1-3 are alpha characters and identify the type of equipment item.

Item Codes

DEF - defibrillator	STR - Stryker frame
IVC - IV controller	SXN - suction apparatus
MON - vital signs monitor	OAN - oxygen analyzer
POX - pulse oximeter	VEN - ventilator
PCA - pain pump (ambit)*	

*The PCA pain pump is not an approved PMI, but is officially tracked by the PMITS. The PCA pain pump is reusable and should be returned to theater via the AF transportation system like all PMI. No exceptions.

b. The 4th position for each equipment item will have an alpha character to specify the manufacturer and model. This means that each type of equipment (i.e., DEF or VEN) can have up to 26 combinations of manufacturer and models in the PMI program. For example, an oxygen analyzer manufactured by MSA such as Miniox 3000 would be “OANA”, while the same manufacturer’s older model, the Miniox III that is still in use, would be an “OANB.” The 4th position would be a separate table of manufacturers and models for each equipment type. The codes for an OAN would not be the same for an MON or VEN. HQ AMC/SGXL will establish and maintain the list and ensure coordination with the PMI Centers.

c. Positions 5-14 characters (numbers or letters) of the item’s serial number (self explanatory). One key issue for the PMI Centers and Office of the Surgeon General, South c/o MCLO-P, and HQ AMC/SGXL is the barcode must contain all 14spaces. If while creating a barcode you have not filled in all 14 spaces add Zeroes right after the 4th position so all 14 spaces are completely filled. Some older bar codes may exist using the5-digit index number (ECN). Those will continue to work and will eventually be changed. The PMI center will identify a user location code in the database of PMITS representing the property book owner.

d. Of the 15 items formally in the PMI program, seven will be tracked as “groups” and will be counted as lot quantities versus by serial number. These items (litters, blankets, etc.) will use a 14 position combination of alpha characters and spaces. Changes or additions will be coordinated through ACSLOG and allow for variations or items unique to a particular Service or PMI Center.

LITTER_NATO or LITTER_OTHER	LITTER STRAPS
LITTER_PADS	I_V_POLES
RESTRAINT SET	SPINAL_BOARD
BLANKET Wool/Cotton	

12-5. REQUESTING BARCODE LABELS

a. The protocol for requesting bar code labels is a controlled process to maintain integrity of the PMI data base. The PMITS label must be ordered from a PMI Center or Office of the Surgeon General, South/c/o MCLO-P, or HQAMC/SGXL. This is at no cost to the unit. The requesting location must complete a Bar Code Request Form before any barcode labels will be printed and sent to the requestor. The PMI Center will refer to the Ownership / Location Table or Office of the Surgeon General, South c/o MCLO-P for unique Army locations.

b. You don’t need to have a PMITS system to label your PMI. The primary reason to put labels on MTOE PMI-Like items is in case float PMI is not available and the unit has to use property book assets to send with an evacuated patient. The PMI Center will mail the labels to the unit for application. However, prior to printing or requesting labels, the unit shall contact this office for ownership assignment in the PMITS database.

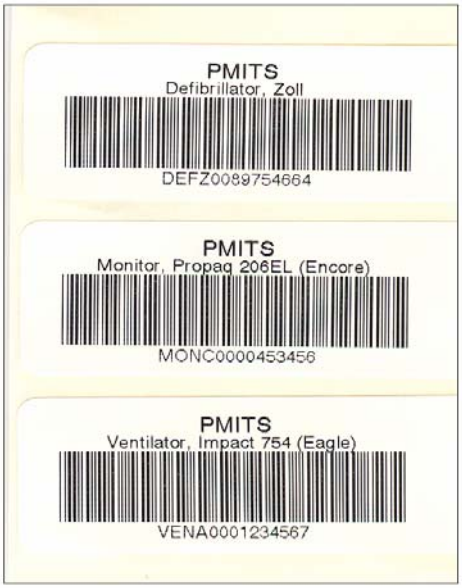


Figure 1:Bar Code Example

Barcode Request Form

HQ AMC SGXL DSN: 779-6952

Requester Name: _____ **Phone:** _____

Mailing Address: _____

When requesting barcodes, the following information must be provided. Please fill out the table below.

Equipment Model:	Identifies the equipment so that we can choose the correct 4 letter id for the barcode (example: Lifepak 10-59)
PMITS Code:	The 4 letter id that we will use in the barcode, this field is not required (example: DEFA)
Index #:	The number assigned by MERC, this is used as the last numbers of the barcode (example: 2056)
Serial #:	The number assigned by the manufacturer of the equipment, this will be entered into the database (example: 00033676)
Project or Ownership #:	Project: the category the equipment belongs to (Unit Asset, WRM - MASF, WRM - AELT, WRM - AE Kits, etc.) we will assign the corresponding number and make it part of the barcode (example: Unit Asset)
	Ownership #: if corresponding ownership # is already known, it can be used instead of the project (example: 047) it will be entered int the PMITS data base
Recert Due Date:	The date when maintenance is due, assigned by MERC (if there is no recertification date, put "None") (example: 2003/03/31)

*Required Fields

*Equipment Model	PMITS Code	*Index #	*Serial #	Project/Unit Ownership#	*Recert Due Date

Equipment Model	Plexus code	Index #	Serial #	Project or Ownership #	Recert Due Date

Figure 2: Bar Code Request Form

CHAPTER 13. HAZARDOUS MATERIAL POLICIES AND PROCEDURES

This chapter addresses the receipt, handling and disposition of Hazardous Materials and Materiel other than Radioactive Materials which is adressed in *MEDCOM Reg 40-35* and in chapter 7 of this SB.

13-1. MANAGEMENT OF HAZARDOUS MATERIEL (HM)

Commanders are responsible for the Hazardous Materiel Management Program in compliance with applicable government and local directives/regulations. This chapter provides policies and procedures for the management of HM and is applicable to any person/organization that has the ability to procure/store HM. Bypassing the Directorate of Logistics/Logistics Division (DOL/Log Div) in obtaining/handling/storing HM does not alleviate responsibility to comply with Federal, State, or local laws. This chapter specifically addresses the storage and use of HM within the DOL/Log Div.

a. This guidance applies to all MEDCOM MEDCENs, MEDDACs, RMCs, the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM), the U.S. Army Medical Research and Materiel Command (MRMC) and its laboratories, the DENCOM, DENTACs, and the VETCOM, Veterinary Regional Veterinary Commands (RVC), and District Veterinary Commands (DVC). Local jurisdictions (to include foreign host nations) may have more stringent rules than those specified in Federal regulations. The installation must adhere to the most stringent rules that apply. A local will be established and kept current to ensure that the procedures meet the State or local laws. For the purposes of this chapter, all MEDCOM MEDCENs/MEDDACs, RMCs, USACHPPM, MRMC laboratories, DENCOM DENTACs, and VETCOM RVCs and DVCs are hereafter referred to as activities.

NOTE: Outside of the Continental United States, installations should consider the *Department of Defense Instruction (DODI) 4715.5* when establishing policies.

b. The policies prescribed in this guidance are applicable to all branches of the DOL/Log Div. The term "logistics activities" is used throughout this guidance to refer to the different logistics areas (property management, medical maintenance, etc.) collectively.

c. Radioactive Materials and RMW are not discussed in this chapter. Procedures for handling Radioactive Materials are addressed in each facility's United States Nuclear Regulatory Commission license. RMW is addressed in *MEDCOM Regulation 40-35* and in chapter 7 of this SB.

d. References used are listed at the end of this chapter. Definitions and Acronyms are listed in the Glossary. To obtain further guidance regarding the handling and/or disposition of HM, contact:

Commander, USACHPPM
ATTN: MCHB-TS-EHM
5158 Blackhawk Road
Aberdeen Proving Ground, MD, 21010-5403

e. General: Properly managed HM poses little or no threat to the environment. However, when improperly managed, HM may contaminate drinking water, air, and soil resulting in injury to plants, animals, and people. The indiscriminate handling of HM is against the law. DoD installations and personnel are required to comply with all Federal, State, and local laws designed to protect the environment and to safeguard the health, safety, and welfare of people. Violators can be held personally liable for cleanup costs and penalties. Violators may include the actual person who caused the contamination as well as the supervisors and commanders who allowed the environmental violations to occur. The best

way to avoid environmental noncompliance citations and penalties is to institute a good pollution prevention program, a HM minimization program, and sound HM management procedures.

1. Minimization of HM is an integral part of the Army goal to reduce hazardous waste (HW). The MEDCOM activities are encouraged to avoid and reduce the use of HM and the generation of HW within the activity. Where HM is needed, users are to adhere to all applicable Federal, State, local, and DOD regulations and Army policies regarding the management of HM. In the absence of regulations, users will apply the best available technology and management in the use, handling, storage, and disposal of HM.

2. Establish procedures to control HMs by limiting their use to the maximum extent practicable without adverse impact on patient care. Use the smallest amount of HM required to accomplish the mission.

(a) The storage activity will retain minimal quantities of HM to effectively support mission requirements.

(b) Order only HMs contained on the current inventory of items stocked or procured through logistics activities. If this is not possible, coordinate the requirement through an appropriate committee for substitution of the requirement. For example, refer a request for nonstocked cleaning supplies to the Infection Control Committee to determine if a suitable stocked item would satisfy the requirement.

(c) Design new systems, equipment, and maintenance procedures to minimize the use of HM. Where HM is required and a substitute non-hazardous or less hazardous chemical is not available, adequate engineering controls and personal protective equipment (PPE) shall be specified, provided, and used.

13-2. HAZARDOUS MATERIAL MANAGEMENT RESPONSIBILITIES, POLICIES, AND PROCEDURES

a. Requests for HMs. Requests for HMs forwarded to Logistics Divisions will be processed as follows: (see para 13-3 for listing of common users and types of HM.)

(1) Establish customer procedures requiring the user to identify whether the ordered item is a HM. Screen the requisition against the inventory listing of hazardous chemical items stored or procured by the activity and developed in accordance with Section 1200, Part 1910, *Title 29*, *Code of Federal Regulations (29 CFR 1910.1200)*.

(2) When a requirement is received for a chemical not on the list, it must be screened against the Hazardous Material Information System (Online or Compact Disk-Read Only Memory) and the USACHPPM Military Item Disposal Instructions system, to determine if the chemical is hazardous. If the chemical cannot be readily identified, contact the requesting department and Preventive Medicine Services for further assistance. If more information is required, contact the USACHPPM Hazardous and Medical Waste Program, DSN 584-3651 or commercial 410-436-3651. This process will enable the supervisor, Preventive Medicine Services, and Logistics to determine if the chemical is hazardous, if a substitute can be obtained, the minimum amount of the chemical needed, the Material Safety Data Sheet (MSDS) requirements, and personnel training requirements.

b. Storage Activities Receiving HMs.

(1) Materials classified by the Department of Transportation (DOT) as hazardous for transport purposes are easily recognized by:

(a) The DOT placards (applicable for standard and nonstandard supplies) on the packaging.

(b) The MSDS accompanying the product as specified by *Federal Standard No. 313D*.

(2) Materials categorized by the U.S. Environmental Protection Agency as hazardous for disposal are extremely difficult to identify on receipt. A listing of HM as outlined in *29 CFR 1910.1200(e) (1)(i)* will be prepositioned in the warehouse. This listing will help in identifying HMs and assist the receiving section with labeling requirements.

(3) Assigned personnel must wear the appropriate PPE and clothing when handling HMs. The applicable MSDSs list PPE requirements and should also be included on the organization Workplace Hazard Assessment as prescribed by *29 CFR 1910.132*.

NOTE: The MSDS-required PPE may not apply to a warehouse person but rather to a laboratory person who actually uses the HM.

c. Storage of HM: All HMs will be properly stored. The DOT HMs will be stored according to procedures contained in

TM 38-410,
DLAM 4145.11,
NAVSUP PUB573,
AFR 69-9,
MCO 4450-12, and
DOD 4145.19-R-1, Section 4, Hazardous Commodities.

Additional storage requirements for DOT items follow:

(1) The HMs will be stored according to compatibility. National stock number sequence has a lower priority than proper compatibility. Assign and record location in automated systems.

(2) Storage facilities must be designed, constructed, maintained, and operated to minimize possible risk of fire, explosion, or any unplanned release of HM or HW.

(a) Incorporate such safeguards as dikes and catchment areas.
(b) Contain the flow of hazardous substances.
(c) Allow for chemical compatibility considerations.
(d) Have adequate safeguards, that is, covered lighting (explosion-proof where required); an accessible eye wash/shower system that requires no more than 10 seconds to reach with an unobstructed travel distance no greater than 100 feet from the hazard (*American National Standard Institute Z358.1-1998*); fire protection, such as sprinklers, fire walls, extinguishers (*29 CFR 1910* and *National Fire Protection Association (NFPA) 45* requirements), safety equipment, and MSDSs. The MSDSs must be in close proximity to the HM storage room.

NOTE: Exposure to highly corrosive chemicals may require that the eye wash/shower systems be installed within the room near the hazards.

(e) Display a placard on the outside of the building or storage facility in accordance with *NFPA 325*.
(f) Allow for adequate ventilation.

d. Hazard Communication Program (HCP). All logistics activities will implement the HCP, as required by *29 CFR 1910.1200*. The HCP requires each branch in the DOL/Log Div that stores HM to protect their employees by communicating chemical hazard information through hazard warning labels, MSDSs, and employee training programs.

e. Transportation Requirements: Transportation requirements for HM are prescribed in *49 CFR 107 and 49 CFR 171 through 178.*

f. Training Requirements: All personnel (including supervisory personnel) who use, work in, or operate HM storage areas will receive hazardous communication training as prescribed in *29 CFR 1910.1200(h)*. Contact the installation Preventive Medicine Service, Environmental Office, and/or Safety Office for further information about training.

g. Inspection Requirements: Inspect HM storage areas monthly. At a minimum, the inspection will:

(1) Identify any leaking or damaged containers and ensure appropriate action is taken to correct such deficiencies.
(2) Ensure proper segregation of HMs.
(3) Ensure proper labeling and marking of all containers.
(4) Verify rotation of inventory to ensure older materials are used before new stock.
(5) Validate only needed materials are on hand/being purchased.
(6) Ensure spill containment kits and safety equipment are:

(a) On hand and in serviceable condition.

(b) Available in sufficient quantities to meet spill containment needs based on types and quantities of HM being stored or used. See para. 13-4 for guidance on the development of a Spill Contingency Plan Standing Operating Procedure.

(c) Replenished or replaced after use.

(d) Costs to procure and maintain spill kits should be included in the Environmental Program Requirements Report.

13-3. COMMON HAZARDOUS MATERIAL USERS

Departments, services, branches, or sections that can generate toxic and HM are:

Department	Materials Used
Nursing	Alcohol, disinfectants, cytotoxic drugs, etc.
Radiology	developing chemicals, disinfectants
Surgery	Anesthetics, disinfectants, flammable liquids
Laboratory	flammable liquids, toxic and poisonous chemicals
Housekeeping	Disinfectants, cleaning compounds
Facilities Operations and Maintenance	cleaning compounds, solvents, paints, glues, flammable liquids
Physical Therapy	cleaning compounds, disinfectants
Pharmacy	cytotoxic drugs, flammable liquids

13-4. SPILL CONTINGENCY PLAN (SCP)

a. General:

1. Handle, use, and store all HM to avoid or minimize the possibility of an accidental spill and potential pollution of land, air, and water.

2. HM storage facilities will be designed to:

(a) Incorporate such safeguards as dikes, catchment areas, and relief vessels.

(b) Contain the flow of hazardous substances.

b. Responsibilities: Supervisors of storage activities with substances hazardous to the environment will:

1. Keep a copy of the installation's Spill Prevention Control and Countermeasure Plan and the installation SCP on file.

2. Develop and implement a local SCP SOP that contains procedures and provides resources to prevent spills based on the guidance outlined in paragraph 3, below.

3. Ensure that all hazardous substances are used, stored, and otherwise handled so as to avoid or minimize the possibility of spills.

4. Identify, program, and budget for the staffing, materials, equipment, Safety and Occupational Health training programs, and periodic health monitoring necessary for personnel to carry out spill prevention, countermeasures, control, and emergency response. Identify requirements to the Installation Environmental Engineer for inclusion in their submission of the installation's *EPR Report* (*AR 200-1*, paragraph 13-5).

5. Coordinate with the Safety Officer, Environmental Science Officer, and Installation Environmental Engineer to identify adequate safeguards for preventing spills of stored hazardous substances (that is, dikes, catchment areas, etc.).

6. Report all releases/spills of hazardous substances in accordance with the installation SCP.

c. Developing an SOP: Guidance on developing an SCP SOP includes minimizing hazards to human health and environment. At a minimum, the SCP SOP must:

1. Address specific responsibilities.

2. Contain instructions on prompt and adequate reporting, containment, and spill cleanup of hazardous substances that occur at or near the area of operations.

3. Contain a description of the actions facility personnel must take to comply with *40 CFR 265.51 and 265.56* in response to fires, explosions, or any unplanned release of HW or HW constituents to air, soil, or surface water at the facility.

4. Describe arrangements agreed to by local police departments, fire departments, hospitals, contractors, and State and local emergency response teams to coordinate emergency services, pursuant to *40 CFR 265.37*.

5. List names, addresses, phone numbers (office and home) of all persons qualified to act as emergency coordinator (see *40 CFR 265.55*). This list must be kept current. Where more than one person is listed, name one as primary emergency coordinator, and list the others in the order in which they will assume responsibility as alternates.

6. Include a list of all emergency equipment at the facility (for example, fire extinguishing systems, spill control equipment, communications and alarm systems (internal and external), and decontamination equipment). This list must be kept current. In addition, the plan must include the location and a physical description of each item on the list, and a brief outline of its capabilities.

7. Include an evacuation plan for facility personnel. This, plan must describe signal(s) used to begin evacuation, evacuation routes, and alternate evacuation routes.

CHAPTER 13 REFERENCES

1 Current version of the *Joint Commission Comprehensive Accreditation Manual for Hospitals, Joint Commission on Accreditation of Healthcare Organizations*.

2 *ANSI Z358.1-1998*, American National Standard for Emergency Eyewash and Shower Equipment, 1998.

3 *29 CFR, Part 1910, Subparts H, I, and Z*.

4 *40 CFR 261*, Identification and Listing of Hazardous Waste (Subparts C and D)

5 *40 CFR 265*, Interim Status Standards for Owners and Operators of Hazardous Waste Treatment, Storage, and Disposal Facilities.

6 49 CFR Transportation (Parts 107, and 171-178).

7 *Federal Standard 313D*, Material Safety Data, Transportation Data, and Disposal Data for Hazardous Materials Furnished to Government Activities, 3 Apr 96.

8 *NFPA 45*, Fire Protection for Laboratories Using Chemicals, latest edition.

9 *NFPA 99*, Health Care Facilities, latest edition.

10 *NFPA 101*, Life Safety Code, latest edition.

11 *NFPA 325*, Fire Hazard Properties of Flammable Liquids, Gases, and Volatile Solids, latest edition.

12 *DoD 4145.19-R-1*, Storage and Materials Handling, latest edition.

13 *DoD 6050*, Hazardous Material Information System (CD-ROM or online)

14 *DoDI 4715.5*, Management of Environmental Compliance at Overseas Installations, latest edition.

15 *AR 40-5*, Preventive Medicine, latest edition.

16 *AR 200-1*, Environmental Protection and Enhancement, latest edition.

17 *AR 385-10*, The Army Safety Program, latest edition.

18 *AR 420-49*, Utility Services, latest edition

19 *AR 700-143*, Performance Oriented Packaging of Hazardous Materials, latest edition.

20 *TM 38-410*, Storage and Handling of Hazardous Material, latest edition.

21 *MEDCOM Regulation 40-35*, Management of Regulated Medical Waste, latest edition.

22 *Executive Order 12856*, *Federal Compliance with Right-to-Know Laws and Pollution Prevention Requirements*, 3 Aug 93.

23 *Emergency Planning and Community Right-to-Know Act of 1986*.

24 *USAMEDCOM Business Operations Management Bulletin XX-XX, Hazardous Waste Policies and Procedures*.

25 The Military Item Disposition Instructions (MIDI) and Military Environmental Information Source (MEIS) contain technical guidance for disposal of small, unused quantities of Medical Materiel, hazardous waste, non regulated special waste, Regulated Medical Waste (RMW) and excess Medical Materiel. To obtain this guidance contact

Commander, USACHPPM
ATTN: MCHB-TS-EHM
5158 Blackhawk Road
Aberdeen Proving Ground, MD 21010-5403

APPENDIX A

SIMILAR ASSET/ESTIMATED FMV WORKSHEET

APPENDIX A.
SIMILAR ASSET/ESTIMATED FMV WORKSHEET

INSTRUCTIONS

The Similar Asset/Estimated FMV Worksheet is used to document the estimated acquisition cost and acquisition date for capital assets lacking proper source documentation. This worksheet, when properly completed, serves as a substitute for original acquisition documentation and should be used when all attempts to locate actual documentation have been exhausted.

Section A (Capital Asset General Information):
This information is required to accurately identify the asset. This information should be obtained through physical examination, observation, and inquiries with using personnel.

Section B (Similar Asset Comparison):
This section allows the activity to estimate the acquisition cost and useful life of the capital asset. It is important that every effort is made to ensure that the similar asset is a close match.

Once a similar asset is found, source documentation, if available, should be obtained to substantiate acquisition cost and date.

If a similar asset cannot be located, Step 2 of Section C should be completed.

Section C (Determine Acquisition Cost):
If copies of the source documentation of the similar asset are available, record the acquisition cost in Step 1. Include Other Costs (installation, site prep, training, etc.) if known or listed on the similar asset source documentation.

If a similar asset cannot be located, estimate the fair market value of the asset by using other sources of pricing information (e.g., FEDLOG, GSA acquisition schedules, vendor quotes). Obtaining this information mat require consultation with other activity personnel (e.g., Resource Management, Contracting, Materiel Management).

Document the source of the estimated fair market value information and record the value amount in Step 3 of this section.

Section D (Determine Acquisition Date):
If source documentation for the similar asset was available, record the acquisition date on the lines listed in Step 2.

If source documentation could not be obtained for the similar asset, the acquisition date will be determined by judgmentally selecting the most appropriate date from Step 2.

Section E (Documentation Requirements):
File this worksheet and all supporting documentation in accordance with *SB 8-75-11*, Chapter 5. The file is maintained until the asset is disposed. The file must accompany the equipment upon transfer or turn-in.

Certification:
The PBO will sign and date this form to certify the accuracy of this information.

(continued) Appendix A. SIMILAR ASSET/ESTIMATED FMV WORKSHEET

The Similar Asset/Estimated FMV Worksheet is used to document the estimated acquisition cost and acquisition date for capital assets lacking proper source documentation. This worksheet, when properly completed, serves as a substitute for original acquisition documentation and should be used when all attempts to locate actual documentation have been exhausted.

A. Capital Asset General Information

UIC/Activity Name: _____

Location: _____

Hand Receipt/Customer: _____

Document Number: _____

Nomenclature: _____

Stock Number/Item ID: _____

Serial Number: _____

Manufacturer: _____

MMCN/ECN: _____

Method of Acquisition:

Local Purchase ____ Requisition ____ Transfer _____ Donated _____ Found _____

B. Similar Asset Comparison:

Location of similar asset: _____

Activity owning similar asset: _____

Similar asset comparison:

	Capital Asset	Similar Asset
Nomenclature:	_____	_____
Stock Number/Item ID:	_____	_____
Serial Number:	_____	_____
Manufacturer:	_____	_____
Model:	_____	_____
Model Year:	_____	_____
Description of Function:	_____	_____
Acquisition Cost:	_____	_____
Receipt Date:	_____	_____

C. Determine Acquisition Cost:

1. If the assets are similar, obtain copies of the acquisition documentation for the similar asset and attach to this form. Record the following information:

Acquisition Cost: _____

Other Costs: _____

Total: _____

2. If a similar asset cannot be located, estimate the fair market value for the capital asset as of the date acquired. Use one or more of the following sources in determining a fair market value:

Source	Company	Contract #	Acq. Cost	Date
FEDLOG Price	FEDLOG	N/A	_____	_____
GSA Schedule Price	_____	_____	_____	_____
Vendor Quote:	_____	_____	_____	_____

3. Record the following information below:

Estimated FMV: _____

Other Costs: _____

Total: _____

D. Determine Acquisition Date

1. If similar assets are found, obtain copies of the acquisition documents for the similar asset. Record the information below.

2. If source documentation is not available, obtain the acquisition date in the following order:

	Document #	Date
Source Document	_____	_____
Transfer Date on DD Form 1149/DA Form 3161 for transfers	_____	_____
Shipping Date	_____	_____
Inspection Date	_____	_____
Date Found	_____	_____
Determined Acquisition Date		_____

(continued) Appendix A. SIMILAR ASSET/ESTIMATED FMV WORKSHEET

E. Documentation Requirements

File this document as the original source documentation in accordance with *SB 8-75-11*, Chapter 5. The following documentation should be included:

Similar Asset		
Procurement Documentation	Invoice	Receiving Report

FMV Research		
Printout of FEDLOG Entry	Copy of relevant GSA Schedule	Copy of vendor quote

Acquisition date			
Transfer Document	Shipping Invoice	Inspection work order	Copy of physical inventory

CERTIFICATION:

I certify that the capital asset information recorded above is accurate to the best of my knowledge.

_____	_____	_____	_____
Name	Activity	Signature	Date

APPENDIX B

INSTRUCTIONS FOR
RECORDING DIN-PACS MEDICAL SYSTEMS ON THE
ACTIVITY PROPERTY BOOK FOR SITES USING DMLSS

APPENDIX B. INSTRUCTIONS FOR RECORDING DIN-PACS MEDICAL SYSTEMS ON THE ACTIVITY PROPERTY BOOK FOR SITES USING DMLSS

DMLSS users will adhere to the following procedures to establish DIN-PACS as a system on the property book.

1. Establish a due in for the item in accordance with DMLSS procedures.

2. Receive the system in accordance with DMLSS and local procedures. Establish the Equipment Type as "System" (System ECN). This is an actual item and should be the major item of the system. For DIN-PACS, this item will be one of the main servers as identified by the Army PACS Program Management Office (APPMO), phone 301-619-3322. Ensure that the total system acquisition cost, including all PACS components, is reflected on this system ECN.

3. Gain the other components of the system using the DMLSS ETM Gain module with the reason "Component Gain" and Equipment Type of "Component" with an acquisition cost of $O.00. Ensure the components are associated with the system ECN. The device nomenclatures for the components are listed in Table B-1.

Table B-1. Device Nomenclatures

Nomenclatures	Guideline (if any)
Diagnostic Work Stations (4 monitor)	Account for using the CPU serial number
Diagnostic Work Stations (2 monitor)	Account for using the CPU serial number
Review Workstations (2 monitor)	Account for using the CPU serial number
Review Workstations (1 monitor)	Account for using the CPU serial number
Quality Control Workstations (2 monitor)	Account for using the CPU serial number
Quality Control Workstations (1 monitor)	Account for using the CPU serial number
Color QC Lite Workstations	None
RIS Terminals	None
Network Printer	None
Web Server	None
Teleradiology Gateway	None
NT Domain Controller	None
Archive	None
H70 (AIX) Server	None
H50 Server	None
RIS NT Server	None
RIS NT Server	None
C68 Archive	None
C66 Archive	None
Telemaintenance Server	None
Color Review Workstations (2 monitor	Account for using the CPU serial number
DICOM IT (at sites that capture ultrasound images)	

4. Finally, ensure components requiring medical maintenance services have a Maintenance Requirements Indicator of "YES" in the catalog record and appropriate services scheduled.

5. If the DIN-PACS system is already on the property book, then the following is required:

a. Confirm the system ECN is the major item of the system. For DIN-PACS, this item will be one of the main servers as identified by the Army PACS Program Management Office (APPMO), if necessary, change the Equipment Type of the identified major end item to “System.” Do this by opening the appropriate equipment record and selecting “System” in the Equipment Type drop down window found on the Main tab.

b. Validate the total system acquisition cost, including all PACS components is reflected on the system ECN. Update the system acquisition cost by opening the equipment record for the system ECN and click on the Acq. Cost icon on the vertical tool bar. In the Acquisition Cost Change window, adjust the values as necessary. Click OK. Click Save in the Equipment Detail window.

c. Ensure all component equipment records have an Equipment Type of “Component,” the appropriate System ECN and an acquisition cost of $0.00.

d. Identify components requiring medical maintenance services. Update the catalog record to signify which components require maintenance services.

APPENDIX C

MEDCOM GUIDE TO
TDA CHANGES/EQUIPMENT AUTHORIZATIONS

MEDCOM Guide to TDA Changes/Equipment Authorizations

Summary. This pamphlet provides guidance and instructions for preparing and submitting requests for changes to TDA for equipment listed in Section III.

Applicability. This pamphlet applies to all activities assigned to US Army Medical Command (MEDCOM).

Chapter 1
General

1.1 Purpose. The purpose of this pamphlet is to define MEDCOM's role in documentation and set procedures and guidance for preparing and submitting TDA change requests. This pamphlet clarifies guidance from various Army regulations and is intended as a ready reference for use by MEDCOM activities at all levels of command. When a conflict exists between guidance contained in this pamphlet and a Headquarters, Department of Army (HQDA) publication, HQDA policy will be followed. Most MEDCOM medical equipment is authorized by AR 40-61. However, Department of Army (DA) controlled items of medical equipment as identified by *SB 700-20* require TDA documentation. Guidance is found in *AR 71-32*.

Chapter 2
Tables of Distribution and Allowances (TDA)

2.1 Proponecy

The United States Army Force Management Support Agency is the HQDA proponent agent for TDAs. Approval authority for DA controlled TDA equipment is DA, G-3. "DA Controlled" items can be identified by researching the CIC code in SB 700-20. Most items of equipment are found in Chapters 2 and 6. Chapter 4 has been reserved for new or experimental items (Zulu LINs). If the CIC contains the letter "C", the item is a DA controlled item and must be approved by DA, G-3 and USAFMSA prior to being purchased. If the CIC code lists an "O", the item is approvable at MEDCOM level. Only equipment items with Line Item Numbers (LIN) assigned can be added to the TDA. Chapter 8 of SB 700-20 contains a listing of CTA items. CTA items cannot be added to the TDA. The CTA, itself, is the authorization for you to have the item of equipment. The G-3/ FMP TDA Equipment Review and Validation Board will approve or disapprove all TDA equipment requests for all intensely managed items contained in Supply Bulletin 700-20, Chapters 2 and 4, that are coded as Controlled Item Code (CIC) "C" and Reportable Item Control Code (RICC) "2" or equivalent. HQDA controlled items of equipment may only be requisitioned or issued to an organization when it is included in an approved authorization document. For MEDCOM units, this means the item must be approved and listed in the Section III portion of the activity's TDA prior to purchasing. Adherence to this policy will be an item of command interest in future Command Logistics Review Team (CLRT) visits.

The MEDCOM retains the authority to document all equipment transfers between paragraphs inside a specific Unit Identification Codes (UICs). Requests to document transfers of LINs between UICs within the same MACOM will be forwarded to the Equipment Review and Validation Board for decision only if the LINs are intensively managed as noted above. All requests to document Inter-Command equipment transfers must be submitted through G-3/7/ FMP to the TDA Unit Equipment Review and Validation Board for review and decision and include concurrence signed by an officer (COL, GS-15 or above) in the losing command. The Equipment Review and Validation Board will convene no earlier than the 16th day of each month. Board decisions will be distributed no later than the last working day of each month. After the Board approves the DA Form 4610-R, G-3/7/FMP will approve a documentation strategy. If the

LIN is critical to the unit or activity then an Out of Cycle (OOC) document will be directed for implementation. The HQ, MEDCOM is the approval authority for those DA controlled items coded "MAPP" (MACOM approval) in *SB 700-20*, those included in the Force Management Bulletin Board for which requirements have been established in Basis of Issue Plans (BOIPs) and approved by HQDA and those select DA controlled items of equipment for Training Support Centers for which USAFMSA granted a waiver.

BOIPs are developed for new or improved items of equipment. A BOIP describes in detail a new item, its capabilities, component items of equipment, where the item is to be used, and identifies the associated support items of equipment and personnel. BOIPs are required documents used to plan and manage the introduction of developmental and non-developmental items of equipment. It is not an authorization document. It is a requirements document!

The MEDCOM retains the authority to document all equipment deletions.

2.2. How TDAs are Organized

a**.** TDA Development. The TDA prescribes the organizational structure for a unit having a support mission for which a Table of Organization and Equipment (TOE) does not exist and may include civilian positions. They are developed based on the type and level of workloads associated with the unit's mission.

b. TDA Composition. The TDA document is composed of three sections as follows:

(1) *Section I, General*. Includes unit designation, mission statement, capabilities, and administrative data.
(2) *Section II, Personnel Allowances*. Contains by paragraph and line number, detailed information on required and authorized personnel, followed by a recapitulation by civilian and/or military grade and skill and Army Management Structure Code (AMSCs), of all positions in the organization.
(3) S*ection III, Equipment Allowance*. Contains by paragraph and LIN, all equipment required and authorized for the unit, followed by a recapitulation in LIN sequence.

2.3. Responsibilities

Installation/Activity Commanders will:

a. Ensure that no DA controlled items of equipment are purchased prior to receiving approval from the DA, G-3.
b. Report unused equipment as excess and delete from authorization documents unless justified for retention by a letter request or an economic analysis or as job peculiar.
c. Institute procedures to ensure turn-in or transfer of excess equipment identified by equipment authorization surveys within timeframe identified.
d. Designate one person within logistics as the Equipment Manager. This would normally be the Property Book Officer (PBO).

2.4. Equipment Usage Management

In the area of equipment usage management, the Army's objective is to obtain optimum use and efficient management of equipment used by TDA activities to meet mission requirements with the minimum of equipment. Usage of medical equipment will be managed per *AR 40-61*.

2.5. Guidelines for Changing Authorization Document

Most changes originate at the unit level with the need or desire for changes (more, less or different equipment).

a. How to Submit a Change. Use the following steps to submit an authorization document change:

(1) Determine the change needed.

(2) Consult the current and future versions of the TDA to see if the change has already been applied. Note: The activities' Resource Management Division has copies of the latest TDA and change documents.

(3) Prepare the request for change utilizing guidance in this document, DA Form 4610-R, *Equipment Changes in MTOE/TDA,* and *AR 71-32*.

(4) Make sure the justification is clear and can be understood by someone not familiar with your unit organization or method of operations. MEDCOM unit structure is very diversified; no two or alike. The clearer and more logical the justification, the better the chance it will be approved. Requests for equipment changes must be approved by the Equipment Review and Validation Board managed by DA, G-3.

(5) Ensure all numbers add up.

2.6. Procedures For Changing TDA Equipment

An activity submits a completed DA Form 4610-R, *Equipment Changes in MTOE/TDA*, utilizing the new automated FMSWEB DA Form 4610-R Tool (Instructions are in Annex A and B). Currently a security clearance is required to access this site. Efforts are being made to change this requirement. Once the form has been completed it will automatically appear in the FMSWEB inbox of the MEDCOM Command Approver. The Command Manger will, in turn, ensure that all requirements of *AR 71-32* have been met and will forward the electronic form for presentation to the DA G-3 Equipment Review and Validation Board. If approved at G-3, the packet will then be submitted to USAFMSA for documentation in the next Management of Change (MOC) window. The MOC window usually opens in January of each year.). There is no longer a requirement to submit the manually prepared DA Form 4610-Rs as in the past unless access to the FMSWEB Tool is not granted. If the packet is disapproved, it will be sent back through the chain of command for rework or more justification. The importance of the justification cannot be overstated. Justifications should be very thorough and explain why the item is needed. One line justifications are no longer adequate for presentation to the board. *AR 71-32*, Appendix E provides a comprehensive checklist to follow in writing justifications. The following are important areas that need to be addressed in each justification:

a. Show that the request has been reviewed by interested staff agencies (As applicable).
b. Include a statement in the justification on why like items presently authorized cannot be used to accomplish the mission.
c. State the function the item will serve and how it will be used.
d. State the specific impact on unit mission if the item is not obtained.
e. When the request is for support of a new mission, cite the authority to perform the mission and clearly state how the requirement(s) will be satisfied.
f. When tactical communications equipment is being requested for a TDA unit comply with paragraph D-57 and paragraph N-4, *AR 71-32*.
g. When the request is based on an increase in equipment usage, consider actual use of all like type equipment on the current TDA considered to determine whether the increase can be accommodated within current resources. State why it is not feasible.

h. Include the DA TMDE registration number (*DA Pam 700-20*) with request for TMDE. TMDE should never be procured prior to receiving approval from the MEDCOM TMDE Coordinator.

i. When commercial equipment (*SB 700-20*, Chapter 6) is being requested, consider standard items that are excess to total requirements.

j. When the request pertains to tool sets, test equipment, and other maintenance related items, cite the level of maintenance to be performed, the end item to be maintained and the page numbers of the technical manual ™ that prescribes the specific use.

k. When the request pertains to power driven equipment, include a statement as to the source of power for such equipment.

l. When the request is for Materials Handling Equipment (MHE) provide evidence of coordination with the appropriate installation MHE control office.

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2.7. Before Preparing TDA Equipment Changes

a Contact your Resource Management office to ensure you are reviewing current authorization in the latest approved/projected TDA.

b. If nothing suitable is presently authorized, review *SB 700-20* to determine additional requirements.

c. Determine what items, if any, can be deleted if requested equipment is approved.

d. Ensure current manpower authorizations are sufficient to support additional equipment.

e. Ensure that equipment requested is the minimum essential for mission accomplishment; not just “nice to have”.

f. Ensure the requirement cannot be met by borrowing from another activity.

g. Ensure that mixing of models of the same type of equipment is kept to a minimum or eliminated.

h. Ensure that requested equipment can be maintained with currently authorized maintenance personnel and equipment.

i. Ensure that facility size and structure can accommodate the new equipment.

j. Ensure that requested equipment is compatible with already authorized equipment.

k. Ensure that equipment is not already authorized by a Common Table of Allowances (CTA).

2.8. Preparing TDA Equipment Change Requests

A TDA Equipment Change Request Package will consist of a completed DA Form 4610-R utilizing the FMSWEB DA Form 4610-R Tool as described above in paragraph 2-6.

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Tactical Wheeled Vehicles (TWV): The Tactical Wheeled Vehicle Requirements Management Office (TWVRMO) is tasked by HQDA to review current initial issue quantities; Table of Organization & Equipment (TOE), Modified Table Of Organization & Equipment (MTOE), Table of Distribution and Allowance (TDA), and the Basis of Issue Plan (BOIP) documentation; and associated justification to provide impact analysis and maintain an audit trail of the fluctuations to the overall Tactical Wheeled Vehicle (TWV) fleet. DA Form 4610-R and the TWVRMO Questionnaire for TWV will be forwarded through command channels. Per *AR 71-32*, Chapter 6, all requests for tactical wheeled vehicles will be reviewed by the Tactical Wheeled Vehicle Requirements Management Office (TWVRMO), Fort Eustis, VA. To avoid unnecessary delays TWV requirements should not be mixed with other HQDA controlled equipment on the same request. TWV request packets should be sent through MEDCOM and not directly to the TWVRMO. MEDCOM will review and forward the request.

(4) *Non-tactical Vehicles (NTVs)*: If an organization has their own account with GSA and does not utilize the installation transportation motor pool (TMP) for support, these vehicles must be authorized on the activity’s TDA. If, however, the activity is drawing vehicles from the installation and reimbursing, then these vehicles would be documented in the installation TDA, not the MEDCOM activity’s TDA.

(5) *Government-Owned/Contractor-Operated (GOCO) Equipment*: Submission of DA Forms 4610-R is not required for GOCO equipment. Any contract that obligates the government to provide equipment to a contractor is recognized as an authorization document for purposes of requisitioning. The Contracting Officer for the respective Commands will be the approving authority for this equipment.

(6) *Commercial Non-standard Equipment*: Submission of DA Form 4840-R requesting LIN assignment is required for commercial nonstandard equipment with a unit cost of $250,000 or over. A package consists of a Memorandum of Transmittal, properly completed DA Form 4840, *Request for Type Classification Exemption (TCE)/LIN for Commercial Equipment*, and manufacturer's brochure, photographs, drawings or specifications. These items can then be documented in the TDA once the LIN is assigned and appears in *SB 700-20*. With the exception of those class items listed in *AR 71-32*, Chapter 6, commercial nonstandard equipment with a unit cost of less than $250,000 is subject to local approval. TCEs are normally not required on systems unique to the Army Medical Department such as nurse call systems etc, These should be handled on a case by case basis.

2.9. Equipment not to be Documented in TDAs

a. Equipment authorized in another document and used for the same purpose.

b. Equipment authorized by another TDA.

c. Equipment on hand through temporary loan.

d. RDTE equipment purchased with RDTE funds.

e. Maintenance float, sizing float, repair parts and expendable or durable items.

f. Equipment procured with non-appropriated funds.

g. Prefabricated buildings.

h. Operational float stocks obtained under *AR 710-1*.

i. Real property.

k. Equipment procured exclusively for DoD civil defense efforts.

l. Any nonexpendable item of serviceable equipment that is withdrawn from the Defense Reutilization and Marketing Office (DRMO).

m. Equipment used for experiments and tests.

Chapter 3
Guidance for Selected Types of Equipment

3-1. Ammunition and Related Items

a. Targets, target equipment, and ammunition are authorized by *CTA 50-909*.

b. Training ammunition authorizations are provided to MACOMs by DA training ammunition memorandum.

3.2. Armament and Weapons

a. General. Weapons included in TDAs will be limited to the minimum essential types and quantities.

(1) Individual Type Weapons. These weapons are provided for the protection and security of the unit, personnel in the unit, or the wounded and sick in their charge. Weapons are not authorized for chaplain and general officers. As a rule, individual weapons on hand will not exceed the total number of required, authorized, or assigned personnel. General officers are authorized a weapon per *AR 725-1.*

b. TDA Activities.

(1) Each military individual assigned to OCONUS TDA organizations and to CONUS based TDA organizations with contingency missions to support deployed forces requiring movement of personnel into threat areas will be provided an individual weapon in accordance with the appropriate basis of issue (BOI). The exception is AMEDD personnel assigned to TDA activities in OCONUS commands who will be authorized individual weapons on the basis of one-for-two individuals. Alaska and Hawaii and other areas outside the contiguous United States are included in geographical connotation of OCONUS.

(2) Ceremonial Rifles. Selected honor guards established per *AR 71-32* will use the M14 as the honor guard rifle. Other honor guards not recognized by this regulation but have been approved by MACOM commanders will also use the M14. Honor guards other than described above, color guards, and burial details will be equipped with presently authorized TDA weapons.

(3) Bayonets. Bayonets are authorized for all individuals authorized an individual weapon except medical personnel and medical units, Chaplains are not authorized bayonets, but chaplain's assistants are, since they are issued individual weapons.

3-3. Books

Those nonexpendable books or publications required by TDA units will be included in section III of the TDA if listed in *SB 700-20* and *not* carried on library accounts. Book sets are listed as sets in *SB 700-20*.

3-4. Camouflage Clothing and Equipment

a. *CTA 50-900* authorizes individual camouflage clothing and equipment.

b. Requirements and authorizations for camouflage net requirements will be included in the TDA.

c. Camouflage net requirements for the purpose of supporting specific operations, contingencies, or war plans for a specific geographic area should be justified as operational project items under *AR 710-1*.

3-5. Chaplain and Chapel Equipment

CTA 50-909 authorizes chaplain and chapel equipment.

3-6. Civilian Guard Equipment

CTA 50-900 authorizes civilian guard equipment.

3-7. Clothing and Individual Equipment (CIE)

a. Prescribed Items. The following publications are the only DA authorization documents permitting the use of appropriated funds to procure individual and organizational CIE for personnel in the Army.

(1) *AR 700-84*. Authorizes civilian clothing for military individuals, special measurement clothing and clothing for prisoners in Army installation confinement facilities.

(2) *CTA 50-900*. Authorizes individual clothing and equipment

(3) *CTA 8-100*. This authorizes AMEDD expendable/durable iems.

(4) *CTA 50-970*. This authorizes expendable/durable items (except medical, class V, repair parts, and heraldic).

3-8 COMSEC Equipment

COMSEC equipment to provide secure transmission of information will be documented as required if meeting requirements outlined above and in *SB 700-20*. Note: The old STU III phones are CTA items. The new tactical STE phone is a TDA item.

3-9. Dayroom Furniture

CTA 50-909, Tables 41, 42, and 43 authrorizes dayroom furniture.

3-10. Flags and related Items

a. Heraldic items. Heraldic items are described in *AR 840-10* for display by organizations and individuals such as guidons, flags etc. They will not be included in the TDA.

b. Nonheraldic items. *CTA 50-909* and *CTA 50-970* authorize nonheraldic flags and related items.

3-11. Food Service Equipment

CTA 50-909 authorizes equipment with unit cost less than $250,000 for all Army appropriated fund food service facilities. Army appropriated fund food service equipment costing $250,000 and over is authorized by the TDA.

3-12. Laundry and Dry-cleaning Equipment

CTA 50-909 authorizes equipment with unit cost less than $250,000. Fixed laundry and dry-cleaning equipment costing $250,000 and over is authorized by TDA.

3-13. Materials Handling Equipment (MHE)

For storage operations forklift requirements will be computed as prescribed in AR 71-32, Appendix D-29, Tables D-1, D-2, D-3 and D-4..

3-14. Protective Masks

Protective masks are documented in the TDA as follows:

(1) Each individual (military and civilian) in an OCONUS TDA organization operating in a chemical or biological threat area will be authorized a protective mask of a type commensurate with the individual duty position.

(a) The basis of issue for a civilian in an OCONUS TDA organization is one per emergency essential civilian designated on the OCONUS mobilization TDA and one per civilian designated as host nation support and not otherwise provided a protective mask.

(b) Protective masks are not authorized for family members or other civilians not listed above.

(2) Individuals assigned to CONUS-based TDA organizations with missions to support deployed forces requiring injection of personnel into chemical or biological threat areas will be authorized a protective mask commensurate with the individual's duty position. This also applies to civilian employees who have agreed to deploy with an organization.

(3) CONUS-based non-deployable organizations will include sufficient masks in TDA to meet unique mission requirements or to support individual proficiency.

(4) Units may stock up to 105 percent of the TDA authorization to enhance readiness by facilitating ready exchange or replacement items which are defective or of incorrect size.

3-15. Recreation Equipment

CTA 50-909 authorizes recreation equipment for physical training programs. Recreation equipment costing greater than $250,000 will be placed on the TDA.

3-16. Relocatable Buildings

Relocatable buildings will normally be accounted for as real property and not be included in the TDA.

3-17. Tentage, Tarpaulins, and Related Items

CTA 50-909, Table 61 authorizes tentage, tarpaulins, and related items costing less than $250,000. Items cost greater than $250,000 will be place on the TDA.

3-18. Tool Sets

Tool sets and equipment for machinists, mechanics, repairers, helpers, and similar categories of personnel will be provided to military and civilian personnel on an individual basis in TDAs as required. Consideration will be given to quantities of available equipment, number of shifts in operations and minimum allowances required to accomplish the mission. Standard items should be procured as much as possible.

3-19. Training Devices

Training devices are authorized on the training support center TDA, unless another TDA or TDA paragraph has been authorized as an exception per *AR 25-1*. In turn, the devices will be issued on a loan basis to using activities as required.

3-20. Aircrafts

Aircraft will be authorized for inclusion in TDA units only when a continuing need is demonstrated. Justification will show, by reference to the appropriate TDA, that sufficient supporting personnel and equipment are authorized, or will be authorized to operate and maintain the requested aircraft. Appendix D, Section II Aircraft, *AR 71-32* details requirements of procuring and documenting aircraft.

3-21. Communication Equipment

In TDA activities, communications equipment requirements and allowances will be determined in accordance with policy and procedures in *AR 25-1*. Authorizations will only be approved when justified as a continuous requirement vital to the mission of the unit.

3-22. Motor Vehicles

a. Vehicles will be included in TDA in the minimum justified and approved quantities required to provide essential mobility to maintain the mission capabilities of units and activities.

b. Vehicles will not be authorized to individuals, but will be authorized on the basis of functional or activity requirements.

c. Vehicles will not be authorized for the sole purpose of transporting infrequently moved equipment. DA DCSLOG established a MACOM ceiling for all authorized non tactical vehicles (NTV). Each MACOM has a ceiling with authority to increase, decrease or substitute vehicles between subordinate elements as long as the changes do not exceed the ceiling. The MACOM NTV ceiling can not be increased without express written approval of the DA DCSLOG.

e. The non-tactical wheeled vehicle fleet contains motor vehicles for general purposes and passenger transport purposes. These will be authorized by TDA. Per *AR 71-32*, motor vehicle requirements for this type of vehicle will be authorized in the transportation motor pool paragraph of the installation TDA. The only exception is that GSA lease general purpose and passenger transport vehicles may be documented in the Directorate of Public Works (DPW) paragraph of the installation TDA when the DPW has an existing lease for special purpose vehicles directly with GSA. Running motor pools is not in our core mission; vehicles should be drawn from the installation Transportation Motor Pool when possible. Authorization for prestige sedans are subject to Office of the Secretary of Defense (OSD) and Office of Management and Budget (OMB) approval. Additional information on both tactical and non tactical vehicles can be found in *AR 71-32*, Appendix D, Section IV.

d. Requests for tactical vehicles must be approved by the Tactical Wheeled Vehicle Requirements Management Office (TWVRMO) prior to being submitted to the Equipment Review and Validation Office.

f. Materials Handling Equipment is not considered wheeled vehicles.

3-23. Office Type Furniture and Equipment

Except as otherwise stated *CTA 50-909* is the only DA authorization documents for office type furniture and equipment.

3-24. Test, Measurement and Diagnostic Equipment (TMDE)

a. Activities will comply with the acquisition requirements of *AR 750-43*, *Army Test, Measurement, and Diagnostic Equipment.*

b. Route request through United States Medical Materiel Agency (USAMMA), 1423 Sultan Drive, Suite 100, ATTN: MCMR-MMM-B, Fort Detrick, MD 21702-5001 to the address listed in subparagraph c below.

c. Receipt of acquisition approval from the U.S. Army TMDE Activity, ATTN: AMXTM-LM-A, Redstone Arsenal, AL 35898-5400, is necessary before requisitioning any item of TMDE. The acquisition request is now automated. You may request on-line using website https://TMDE-Register.us.army.mil. You will need an Army Knowledge Online (AKO) login and password to access the TMDE Register.

d. The *AR 750-43* lists those items exempt from acquisition approval. Preventive Medicine activities utilize many items of testing equipment that is exempt from the approval process, e.g., air flow meters, sound level meters etc.

3-25. Research, Development, and Test Equipment (RDTE)

(1) Equipment that will be documented includes:

a. HQDA controlled equipment required for support of base operations at RDTE installations. This includes but is not limited to facility engineer, message center, security, motor pool, and installation maintenance.

b. HQDA controlled equipment required for support of RDTE projects or specific test requirements for a period exceeding 2 years.

c. Items acquired with RDTE funds for testing purposes which are still available at completion of the test program and are reassigned for operational use or inventory will be documented in the TDA.

(2) Equipment that will not be documented includes:

a. Equipment procured with RDTE funds.
b. Special purpose equipment required for RDTE activities.
c. Prototypes required by an RDTE activity to support experiments.

3-26. Morale Support Activities

In order that the morale support activities program can meet the changing needs, interests, and off-duty requirements of the soldier and his or her family, equipment to support these programs are authorized as follows:

(1) Investment ($250,000 and over) equipment- installation TDA.
(2) Expense (less than $250,000) equipment- *CTA 50-909*.
(3) Expendable or durable equipment- *CTA 8-100* and *CTA 50-970*.

Chapter 4
Command Review

Command involvement is of vital importance to ensure that only mission essential equipment is authorized. Review procedures will be established to ensure determination of the need before requesting an item. At the initiating level, the commander involved will explore all feasible alternatives prior to the submission of a material request. When, in the commander's opinion, the item desired is the most efficient and cost-effective to accomplish the mission, he or she will initiate the request

a. When a request for a commercial item is being processed, the reviewing commander will compare the commercial item cost with that of the related standard adopted item, determine whether it is more cost effective to lease or purchase, and select an alternative, when possible, that will eliminate the need for the requested item of equipment.

b. Commanders will review the need for all equipment during each annual inventory. Equipment no longer needed will be turned in, using normal supply procedures, and appropriate document changes will be initiated.

c. Command control of equipment purchases with credit cards is essential to ensure that equipment is not purchased without following the above listed requirements. Controls will be put in place to prevent unauthorized purchases of equipment.

APPENDIX D

ANNEX A & B to

MEDCOM Guide to TDA Changes/Equipment Authorizations

DAMO-FMP
SUBJECT: Table of Distribution and Allowances (TDA) Unit Equipment Review and Validation Board

Annex A: Additional Guidance and Equipment Authorization Documents

1. Additional Guidance:

a. Do not forward to the TDA Unit Equipment Review and Validation Board if the item(s) requested are within the proponent approval authority.

b. When the request is for support of a new mission, cite the authority to perform the mission and clearly state how the requirement(s) will be satisfied by transfer from one or more The Army Authorization Documents System (TAADS) documents. List the deletions.

c. When tactical communications equipment is being requested for a TDA unit, comply with paragraph D-57 and paragraph N-4 of Army Regulation 71-32.

d. Include the DA Test, Measurement, & Diagnostic Equipment (TMDE) Logistics Control Code (AR 750-43) with the request for TMDE at the beginning of the Justification.

e. Prepare and include communication net diagrams for TDA requests (wire or radio diagrams). All attachments require control numbers to be annotated and submitted through command channels to command managers via e-mail. Do not paste any attachments into the FMSWeb DA Form 4610-R tool.

f. When the request pertains to tool sets, test equipment, and other maintenance related items, cite the level of maintenance to be performed, the end item to be maintained, and the Technical Manual (TM) page numbers of the TM that prescribes the specific use.

g. When the request pertains to power driven equipment, include a statement as to the source of power for such equipment.

h. Include a specific statement that the item can be stored and maintained. Indicate whether the personnel associated with the equipment are included only in a Concept Plan or whether they are already in a published TDA.

i. When the request is for materials handling equipment (MHE), provide evidence of coordination with the appropriate installation MHE program manager. (See paragraph D-29 of Army Regulation 71-32).

j. All medical equipment must be reviewed and approved by the Office of the Surgeon General prior to submission to G-37/FMP and TDA Unit Equipment Review and Validation Board.

k. Ensure that the requested equipment meets the minimum essential requirement necessary to accomplish the mission.

2. Regulations That Are Also Equipment Authorization Documents:

a. AR 1-100 Gifts And Donations

b. AR 25-1 Army Knowledge Management And Information Technology

c. AR 40-61 Medical Logistics Policies

d. AR 40-63 Ophthalmic Services

e. AR 70-6 Management Of The Research, Development, Test, & Evaluation, Army Appropriation

f. AR 71-32 Force Development and Documentation – Consolidated Policies

g. AR 350-2 Opposing Force (OPFOR) Program

h. AR 570-7 Equipment Survey Program

i. AR 600-8-1 Army Casualty Program

j. AR 600-8-22 Military Awards

k. AR 608-4 Control And Registration Of War Trophies And War Trophy Firearms

l. AR 670-10 Furnishing Uniforms Or Paying Uniform Allowances To Civilian Employees

m. AR 700-84 Issue And Sale Of Personal Clothing

n. AR 700-90 Army Industrial Base Process

o. AR 710-2 Supply Policy Below The National Level

p. AR 725-1 Special Authorization And Procedures For Issues, Sales, And Loans

q. AR 750-43 Army Test, Measurement, and Diagnostic Equipment

r. AR 840-10 Flags, Guidons, Streamers, Tabards, And Automobile And Aircraft Plates

s. AR 870-20 Army Museums, Historical Artifacts, And Art

Annex B: FMSWeb DA Form 4610-R Tool

1. Initial requirements.

a. Units:
Submit equipment requests via the FMSWeb DA Form 4610-R Tool.

b. Commands:
(1) Command Approvers must request permission from their Command Manager to have approval authority for their Command. Suggest that Commands have more than one person with approval authority. This request must be in a memorandum signed by a COL or GS-15, listing those who are nominated for Command Approval privileges. The Command Approver must have an account on FMSWeb.
(2) Command Approvers approve or disapprove requests from their units. Command approvals must be completed by the close of business of the last working day of the month preceding the TDA Unit Equipment Review and Validation Board. If a LIN is approved by the Command, then the Command Approver assigns a Command Log Numbers as follows: The number will be assigned in sequential order and consist of the Command Control Number (CCNUM) prefix, the sequence number (three digits), and the current fiscal year suffix; for example TC 001-07 would be the first request submitted by TRADOC in fiscal year 2007. The FMSWeb DA Form 4610-R automatically puts in the Command Code and Fiscal Year. The Command assigns the sequence number. One sequence number per UIC, all LIN requests for a specific UIC have the same sequence number for that month. Sequence numbers may only be used once during a fiscal year.

c. Command Managers:
(1) Review, approve (or disapprove) and forward Command Approved HQDA requests to TDA Unit Equipment Review and Validation Board coordinator. Command Managers must review submissions from their Command on the first three working days of the month the TDA Unit Equipment Review and Validation Board meets. USAFMSA equipment requests are between the Command and USAFMSA.
(2) Command Managers will be given permission to approve or disapprove HQDA equipment requests from their Commands.

d. TDA Unit Equipment Review and Validation Board:
(1) Lock Command Manager approved HQDA requests on the fourth working day of the month the TDA Unit Equipment Review and Validation Board meets.
(2) Send Command Manager approved HQDA requests to Board members on fourth working day of the month.

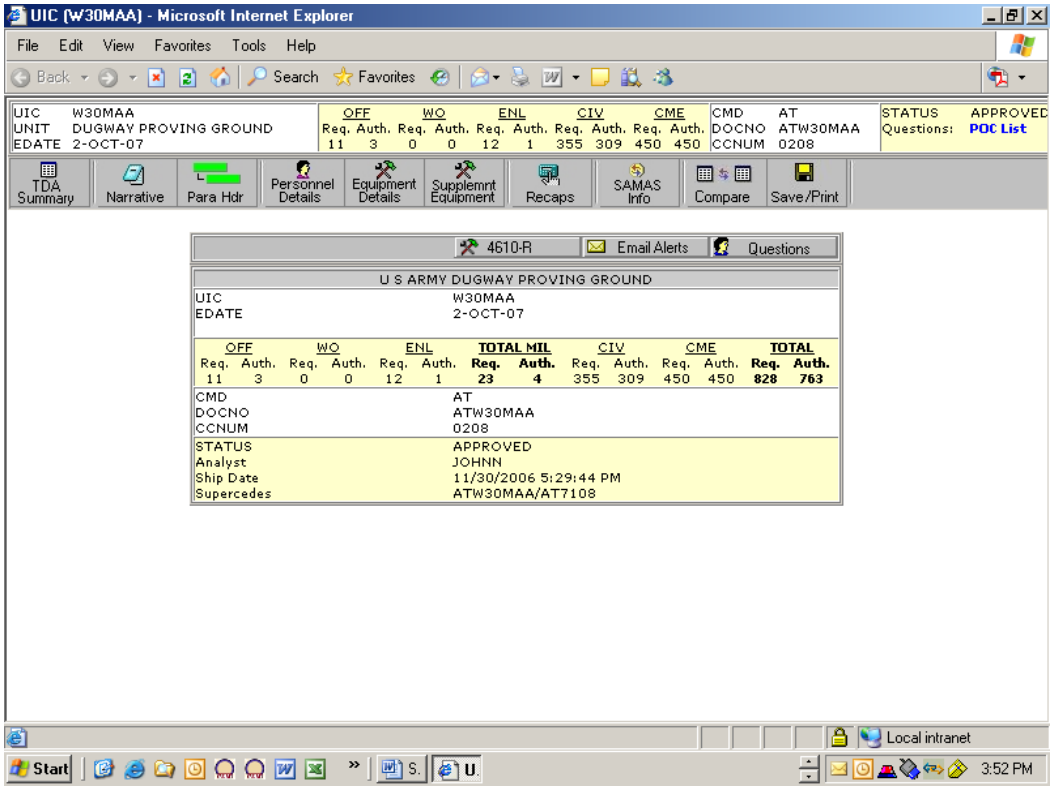
2. Using the DA Form 4610-R Tool.

a. Basic requirements and features:
(1) Users must have an account on U.S. Army Force Management Support Agency (USAFMSA) Force Management System (FMS) Web (FMSWeb).
(2) Each level of approval or disapproval locks out the lower level, i.e. when the Command approves a request, the Requester is locked out; when the Command Manager approves a request, the Command is locked out.

b. Basic tools are:
(1) Current Requests – list of active requests by type, status, command, UIC, etc. A request is considered active until a new CMD/DOCNO/CCNUM has been assigned to the request by USAFMSA or the request is denied at any level.
(2) Archived Requests – list of inactive requests from past Boards and USAFMSA reviews by type, status, command, UIC, etc. and disapprovals at any level

(3) HQDA CMD Managers – list of HQDA Command Managers
(4) FMSA Approvers – list of USAFMSA approvers
(5) CMD Managers – list of Command approvers
(6) TMVRMO LINs – list of Tactical Wheeled Vehicle Requirements Management Office (TWVRMO) LINs

c. Units and Activities
(1) Log into FMSWeb
(2) Click on AUTHORIZED Doc. Review
(3) Click on TDA Documents
(4) Find Table of Distribution and Allowances (TDA) where equipment will be added or deleted by either clicking on Unit By Command, Unit By Sub Command, or Unit By UIC
(5) Open TDA
(6) Click on the 4610-R button in the TDA Summary



(7) In the DA Form 4610-R Request window, enter the following information:
(a) Paragraph
(b) Line Item Number (LIN)
(c) Quantity Required to Add (QTY REQ ADD)
(d) Quantity Authorized to Add (QTY AUTH ADD)
(e) Quantity Required to Delete (QTY REQ DEL)
(f) Quantity Authorized to Delete (QTY AUTH DEL)
(g) New Paragraph Quantity Required (NEW PARA QTY REQ) (new total for paragraph automatically calculated)

(h) New Paragraph Quantity Authorized (NEW PARA QTY AUTH) (new total for paragraph automatically calculated)

(i) Recap Quantity Required (RECAP QTY REQ) (current total on TDA automatically calculated)

(j) Recap Quantity Authorized (RECAP QTY AUTH) (current total on TDA automatically calculated)

(k) Quantity On Hand For UIC (QTY ON HAND FOR UIC)

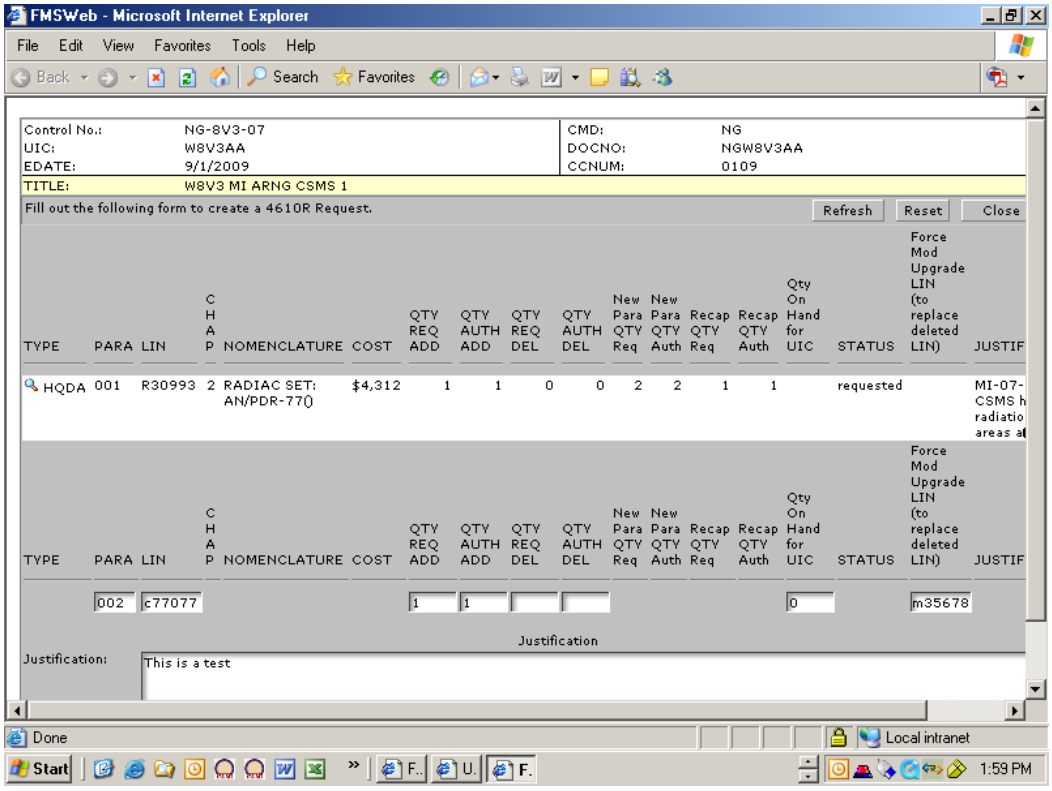
(l) Force Modernization Upgrade LIN (to replace deleted LIN) if an obsolete LIN is being deleted for a modern LIN, enter the modern LIN here. Enter documented

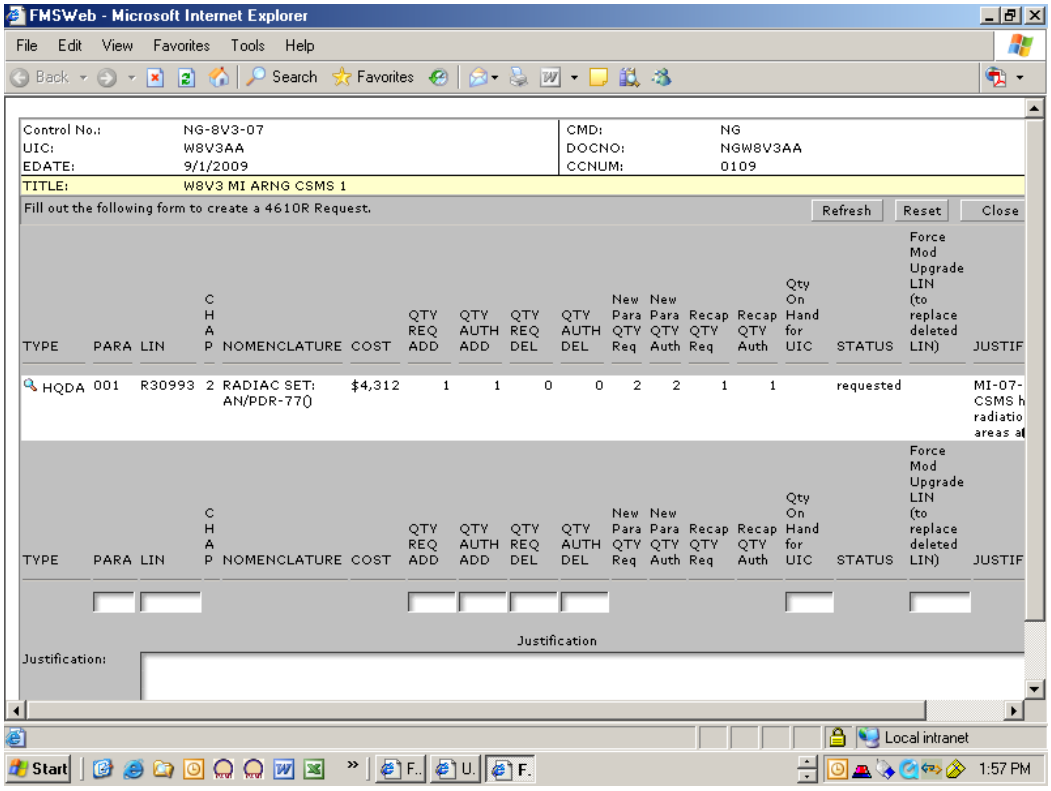
(obsolete) LIN with quantities to be deleted. Enter Force Mod LIN with quantities to be added. Enter justification for the Force Modernization Upgrade LIN.
Then click on Continue.

(m) Justification, up to 255 characters

(n) Click on Continue after all data has been entered for the LIN.

Keep entering paragraph and LINs as appropriate for the UIC, when finished (all LINs are shown in the data entered window), click on the Close Window button to return to the last window.



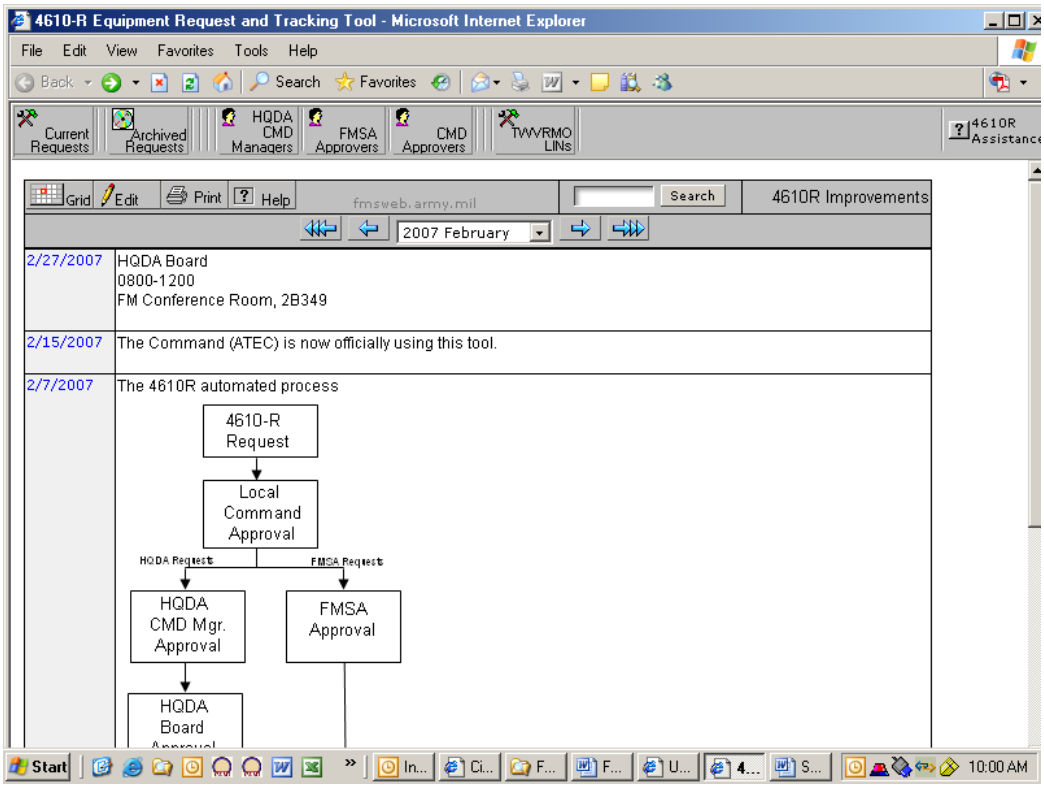


(o) A red flag by the LIN means this item requires Tactical Wheeled Vehicle Requirements Management Office (TWVRMO) review. Click on the little red flag for a prompt to save the TWVRMO LIN Tactical Wheeled Vehicle Justification Questionnaire (TWVJQ) file. The TWVJQ must be submitted to TWVRMO for review and recommendation. TWVRMO web site is http://www.transchool.eustis.army.mil/twvrmo

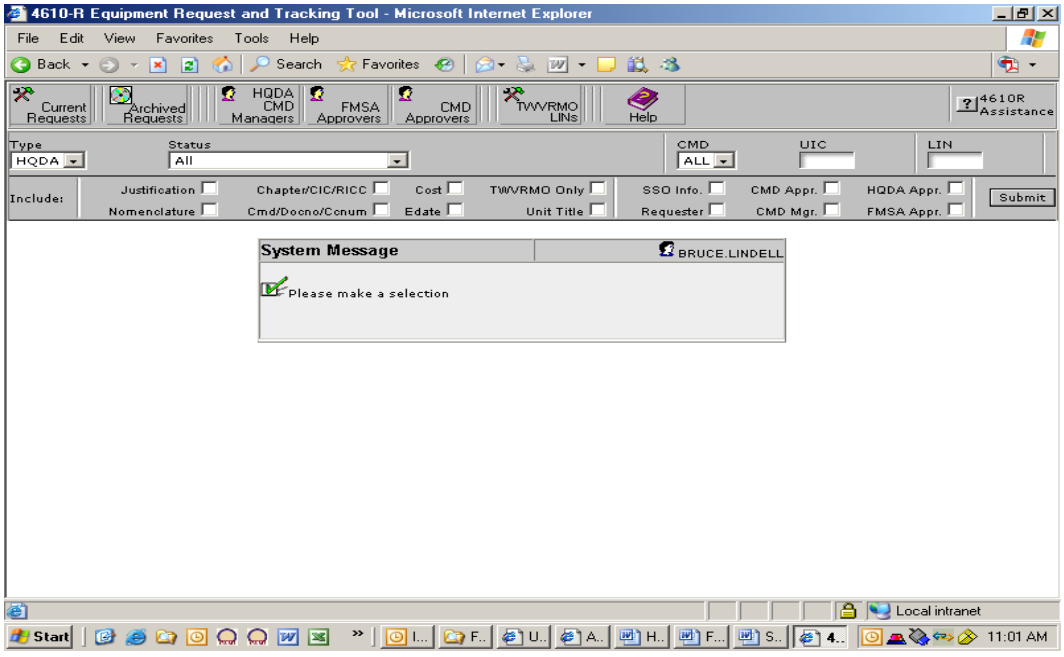
(p) A small thumbs-up icon by the LIN means the item being deleted is because of a LIN Upgrade. Put your mouse over the icon for the upgrade LIN.

(8) In the main FMSWeb window, there is a button for 4610-R TDA Equipment Request Tool. Use this button to determine Current Requests, Archived Requests, list of Command Requesters and Command Managers, and list of TWVRMO LINs.

d. Commands
   (1) Log into FMSWeb
   (2) Click on the 4610-R TDA Equipment Request Tool



3. Click on Current Requests



(4) Click on arrow at the Type Window and chose HQDA
(5) Click on arrow at the Status Window and chose Requested
(6) Click on arrow at the CMD Window and chose your Command Code
(7) Click on any of the following boxes if you wish to see that data:
UIC – enter specific Unit Identification Code

LIN – enter specific Line Item Number (A small thumbs-up icon by the LIN means the item being deleted is because of a LIN Upgrade. Put your mouse over the icon for the upgrade LIN.) (A red flag by the LIN means this item requires Tactical Wheeled Vehicle Requirements Management Office (TWVRMO) review). Click on the little red flag for a prompt to save the TWVRMO LIN Tactical Wheeled Vehicle Justification Questionnaire (TWVJQ) file. The TWVJQ must be submitted to TWVRMO for review and recommendation. TWVRMO web site is http://www.transchool.eustis.army.mil/twvrmo

Justification – justification, up to 255 characters

Nomenclature – nomenclature

Chapter / CIC / RICC – chapter, Controlled Item Code (CIC) and Reportable Item Control Code (RICC) in SB 700-20

Cmd / Docno / CCnum – Command code / document number (command or subcommand code and UIC) / command control number (TDA sequence number and fiscal year)

Cost – cost rounded to the nearest dollar

Edate – effective date

TWVRMO Only – list of only LINs that require TWVRMO review

Unit Title – unit designation

SSO Info. – System Synchronization Officer name and office symbol

Requester – requester

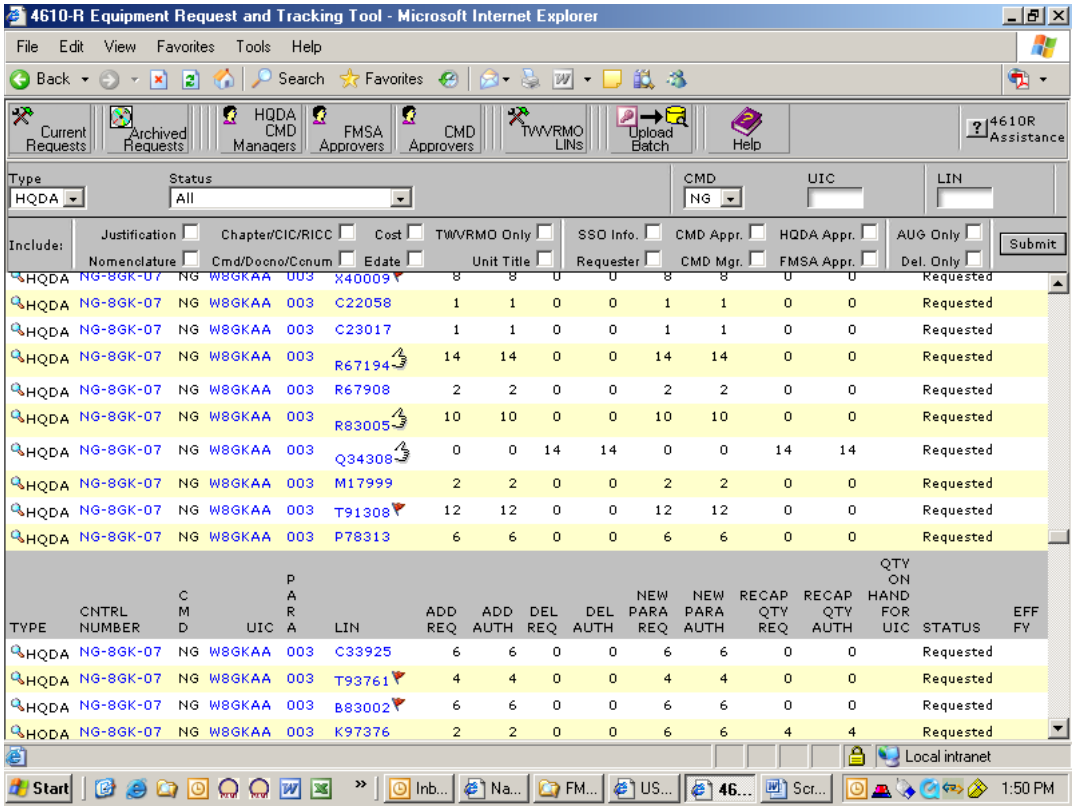
CMD Appr. – Command Approver name and approval or disapproval date

CMD Mgr. – Command Manager name and approval or disapproval date

HQDA Appr. – HQDA TDA Equipment Board lock (being reviewed), approval, or disapproval

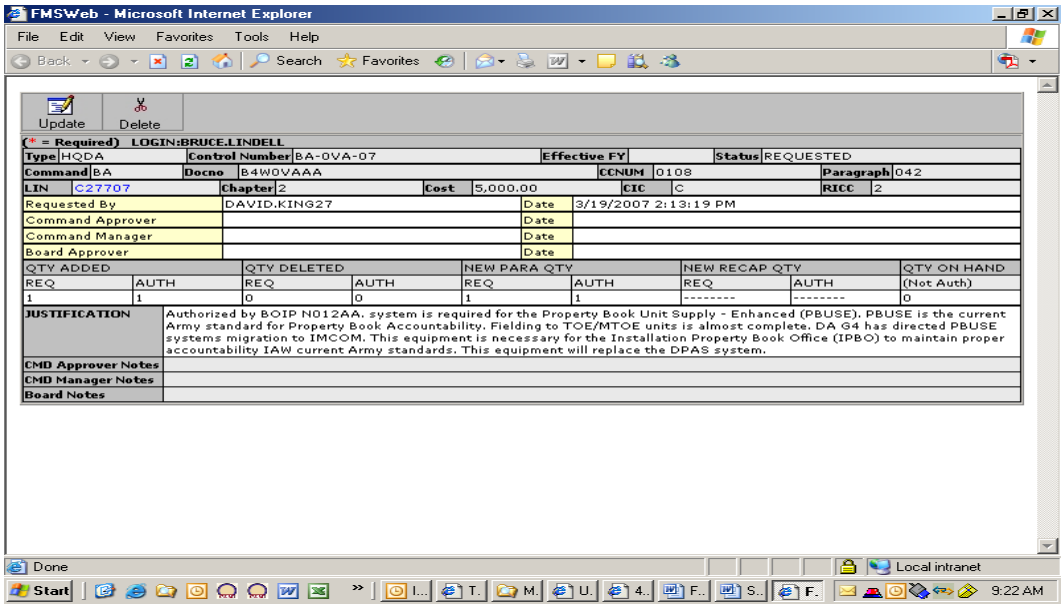
FMSA Appr. – USAFMSA approval (FMSA approved or disapproved LIN)

(8) Click the Submit button for a listing of Requests from units in your Command (if green, LIN is approved, if red, LIN is disapproved at the level shown in Status)

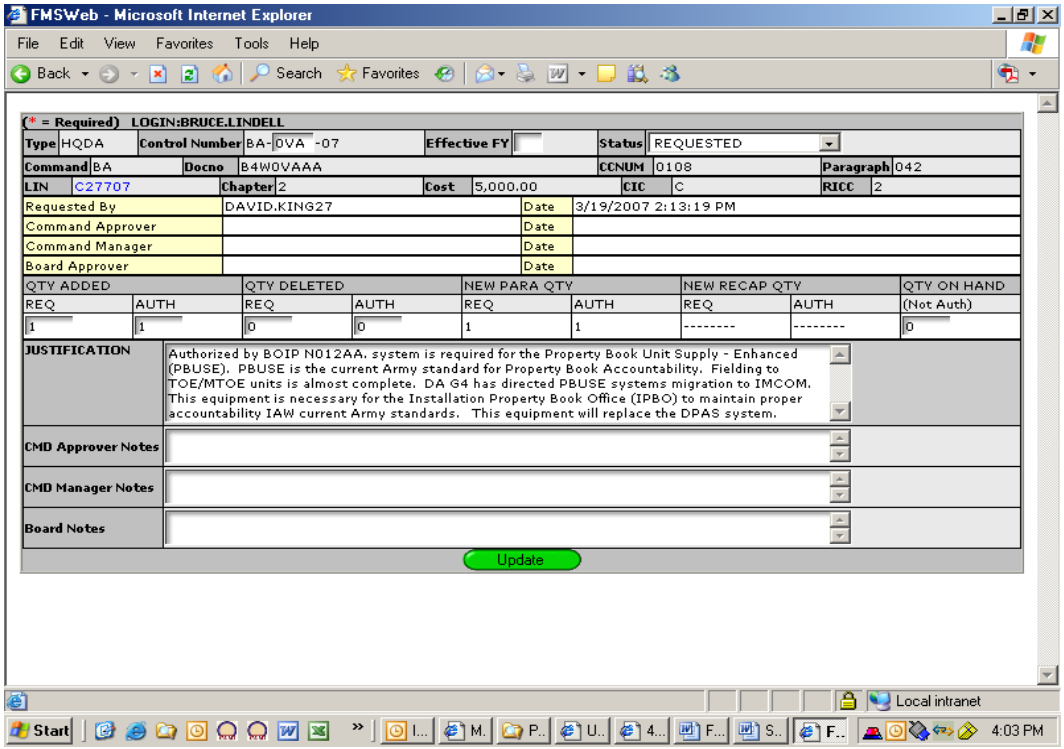


(9) Approving LINs individually

(a) Click on magnifying glass by item to be reviewed



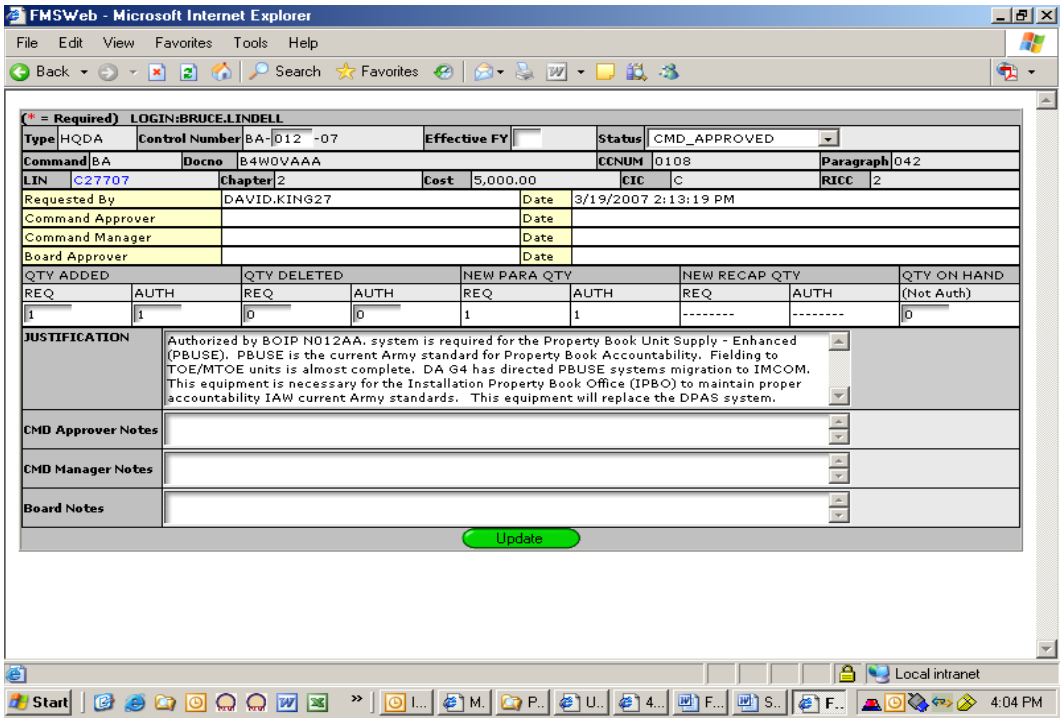
(b) Click on the Update button to make changes



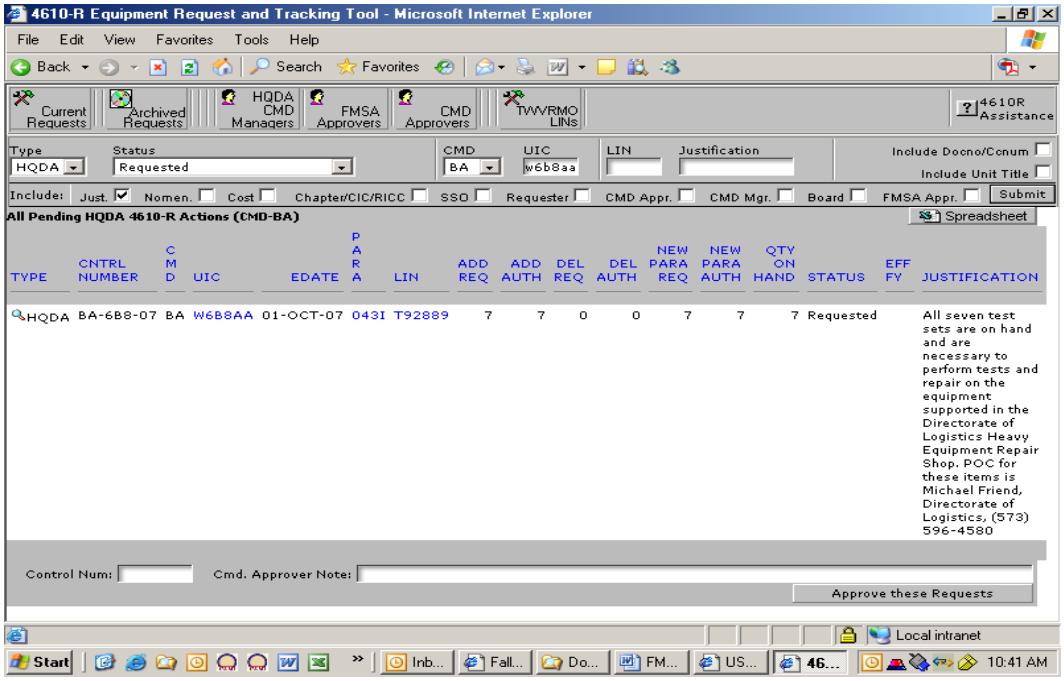
(c) Click on arrow at the Status Window and chose CMD_APPROVED or CMD_DENIED

(d) If CMD_APPROVED (Command Approved), enter the Control Number, one per UIC per month (can be up to three digits, can not have been used in a previous Board submission) (Command Code and FY are entered automatically). Enter any Command Approver

Notes if appropriate. Click on Update. The request can not be approved until the Command has entered a valid Control Number.



(e) Keep reviewing items until finished.

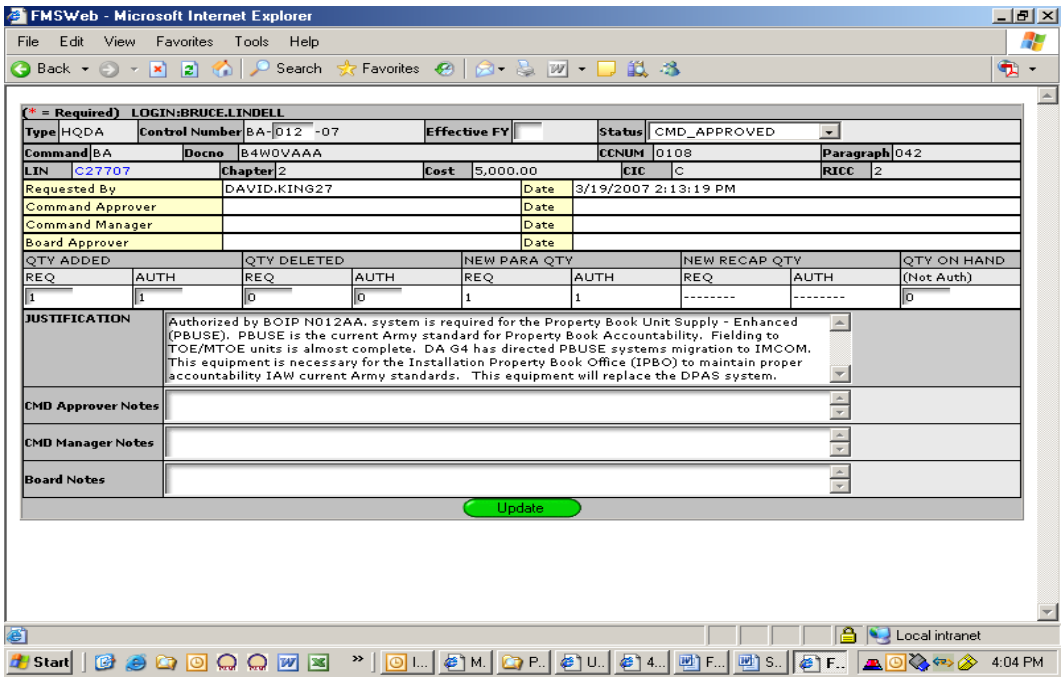


(10) Approving LINs by UIC
(a) Click on arrow in Status Window and chose Local Command Approved
(b) Enter Command Code in the CMD box

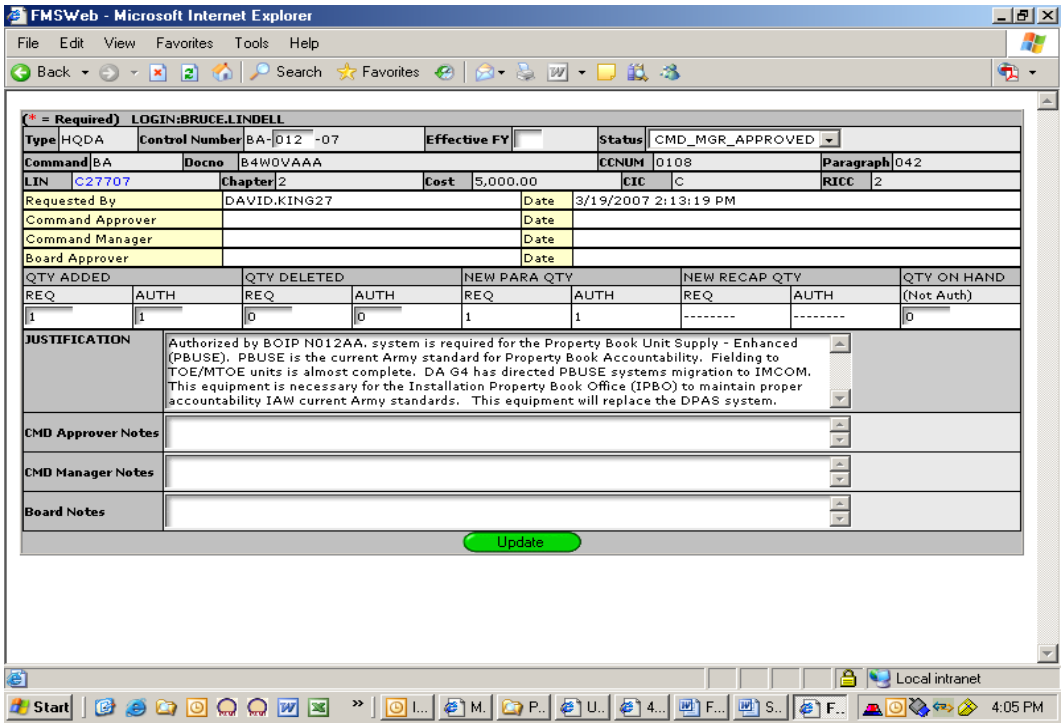
(c) Enter UIC in the UIC box
(d) Check Justification box
(e) Click on Submit
(f) Review LINs being requested and justification
(g) Enter Control Number
(h) If desired, enter Command Approver Notes (up to 200 characters) (these notes will apply to all LINs being approved with that Control Number)
(i) Click on Approve these Requests
Repeat on all UICs that have LINs to be Command Approved

e. Command Managers
(1) Log into FMSWeb
(2) Click on 4610-R TDA Equipment Request Tool
(3) Click on Current Requests
(4) Click on arrow at the Type Window and chose HQDA
(5) Click on arrow at the Status Window and chose Local Command Approved
(6) Click on arrow at the CMD Window and chose your Command Code
(7) Click on any of the following boxes if you wish to see that data:
UIC – enter specific Unit Identification Code
LIN – enter specific Line Item Number (A small thumbs-up icon by the LIN means the item being deleted is because of a LIN Upgrade. Put your mouse over the icon for the upgrade LIN.) (A red flag by the LIN means this item requires Tactical Wheeled Vehicle Requirements Management Office (TWVRMO) review). Click on the little red flag for a prompt to save the TWVRMO LIN Tactical Wheeled Vehicle Justification Questionnaire (TWVJQ) file. The TWVJQ must be submitted to TWVRMO for review and recommendation. TWVRMO web site is http://www.transchool.eustis.army.mil/twvrmo
Justification – justification, up to 255 characters
Nomenclature – nomenclature
Chapter / CIC / RICC – chapter, Controlled Item Code (CIC) and Reportable Item Control Code (RICC) in SB 700-20
Cmd / Docno / CCnum – Command code / document number (command or subcommand code and UIC) / command control number (TDA sequence number and fiscal year)
Cost – cost rounded to the nearest dollar
Edate – effective date
TWVRMO Only – list of only LINs that require TWVRMO review

Unit Title – unit designation
SSO Info. – System Synchronization Officer name and office symbol
Requester – requester
CMD Appr. – Command name and approval or disapproval date
CMD Mgr. – Command Manager name and approval or disapproval date
HQDA Appr. – HQDA TDA Equipment Board lock (being reviewed), approval, or disapproval
FMSA Appr. – USAFMSA approval (FMSA approved or disapproved LIN)
(8) Click on Submit button for a listing of Requests from units in your Command
(9) Approving LINs individually
(a) Click on magnifying glass by item to be reviewed
(b) Click on the Update button to make changes



(c) Click on arrow at the Status Window and chose CMD_MGR_APPROVED or CMD_MGR_DENIED or CMD_MGR_DEFERRED



Keep reviewing items until finished.

(10) Approving LINs by UIC

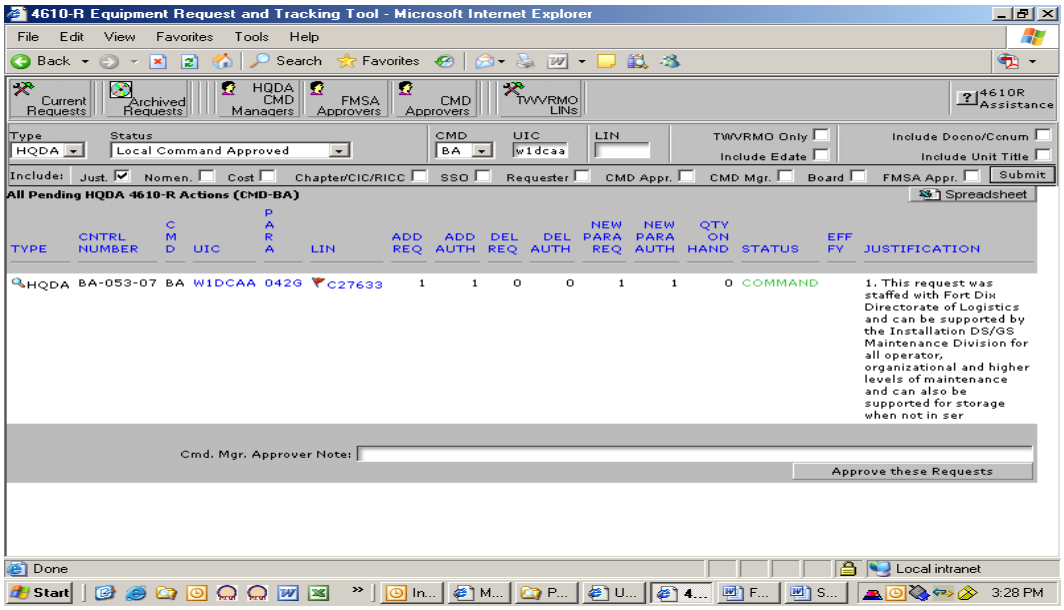
(a) Click on arrow in Status Window and chose Local Command Approved

(b) Enter Command Code in the CMD box

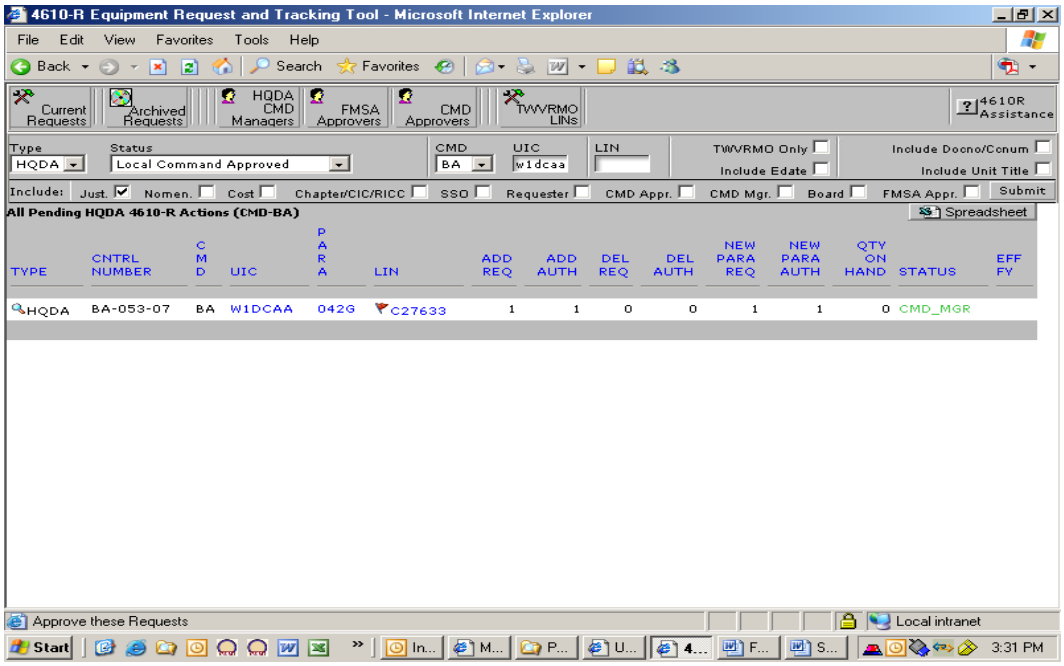
(c) Enter UIC in the UIC box

(d) Check Justification box

(e) Click on Submit
(f) Review LINs being requested and justification
(g) If desired, enter Command Manager Notes (up to 200 characters) (these notes will apply to all LINs being approved with that UIC)



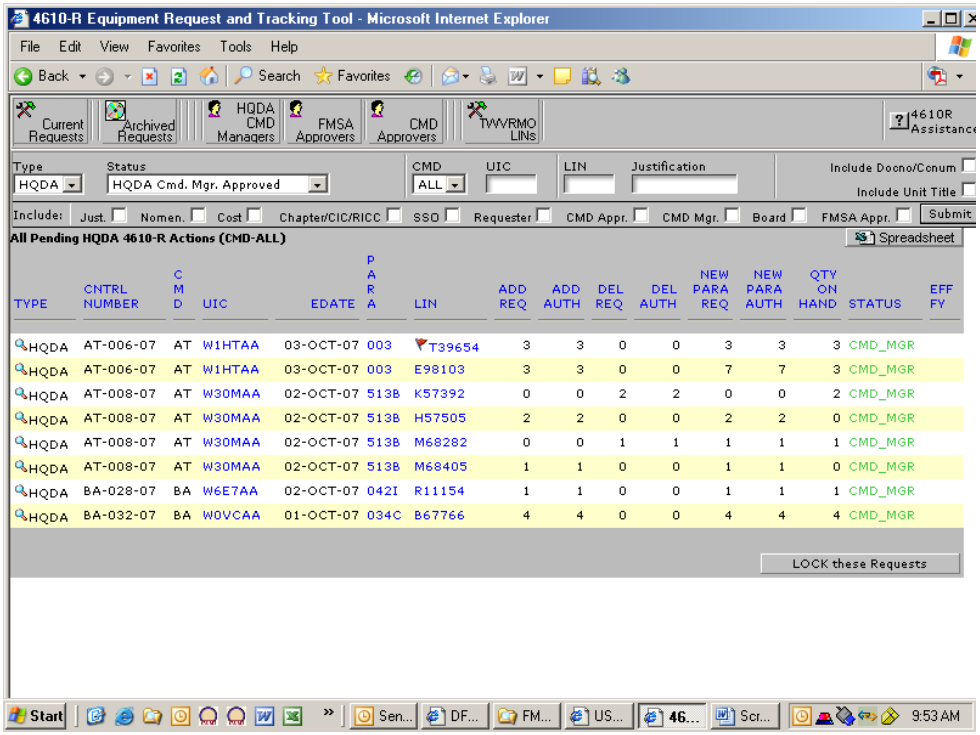
(h) Click on Approve these Requests



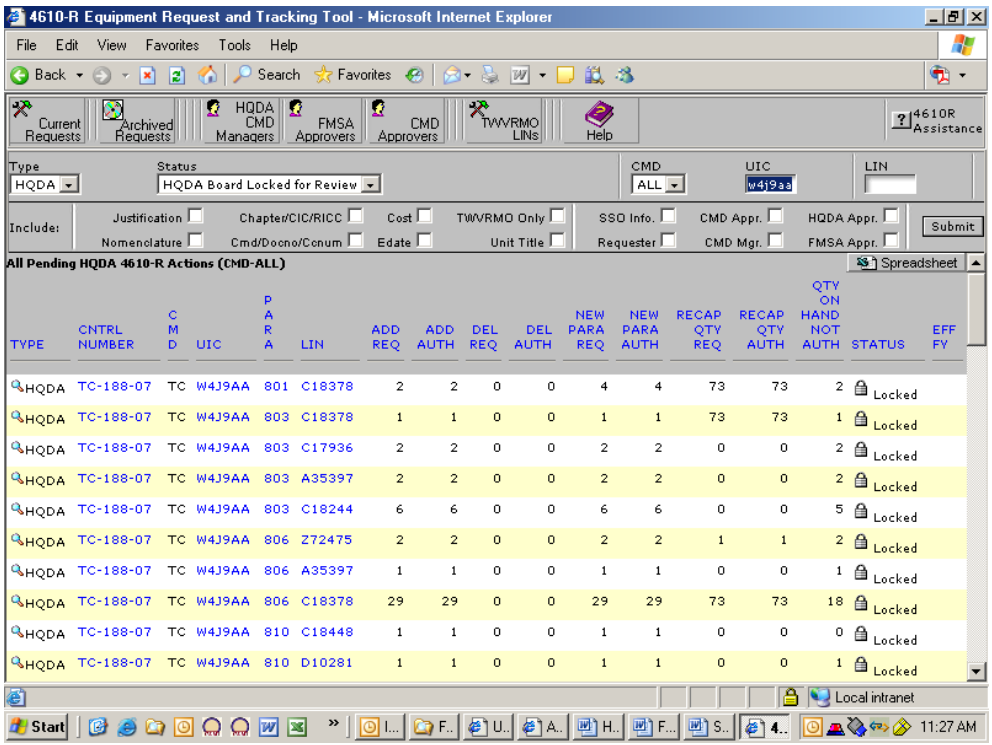
Repeat on all UICs that have LINs to be Command Approved

f. Table of Distribution and Allowances (TDA) Unit Equipment Review and Validation Board
(1) Log into FMSWeb
(2) Click on 4610-R TDA Equipment Request Tool

(3) Click on Current Requests
(4) Click on arrow at the Type Window and chose HQDA
(5) Click on arrow at the Status Window and chose HQDA Cmd. Mgr. Approved
(6) Click on Submit



(6) Click on Lock these Requests (HQDA Board Locked for Review becomes the new status)

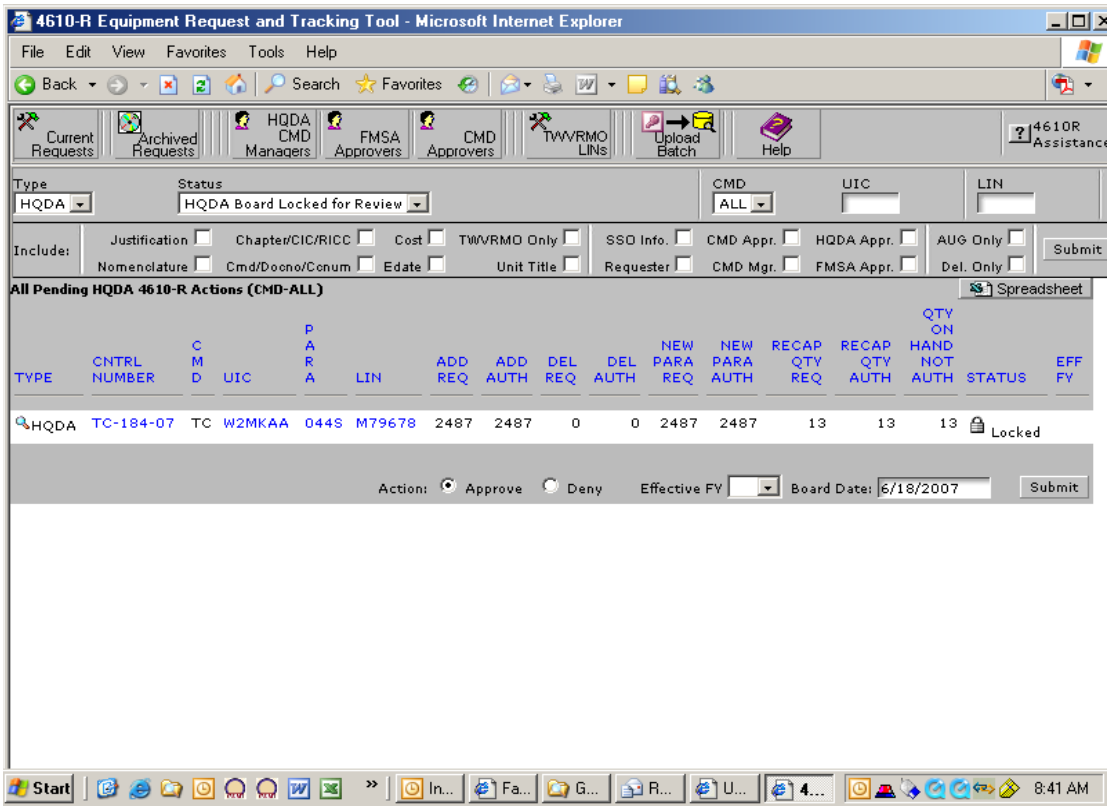


(7) After the Board has met

(a) Click on arrow at the Type Window and chose HQDA

(b) Click on arrow at the Status Window and chose HQDA Board Locked for Review

(c) Click on Submit



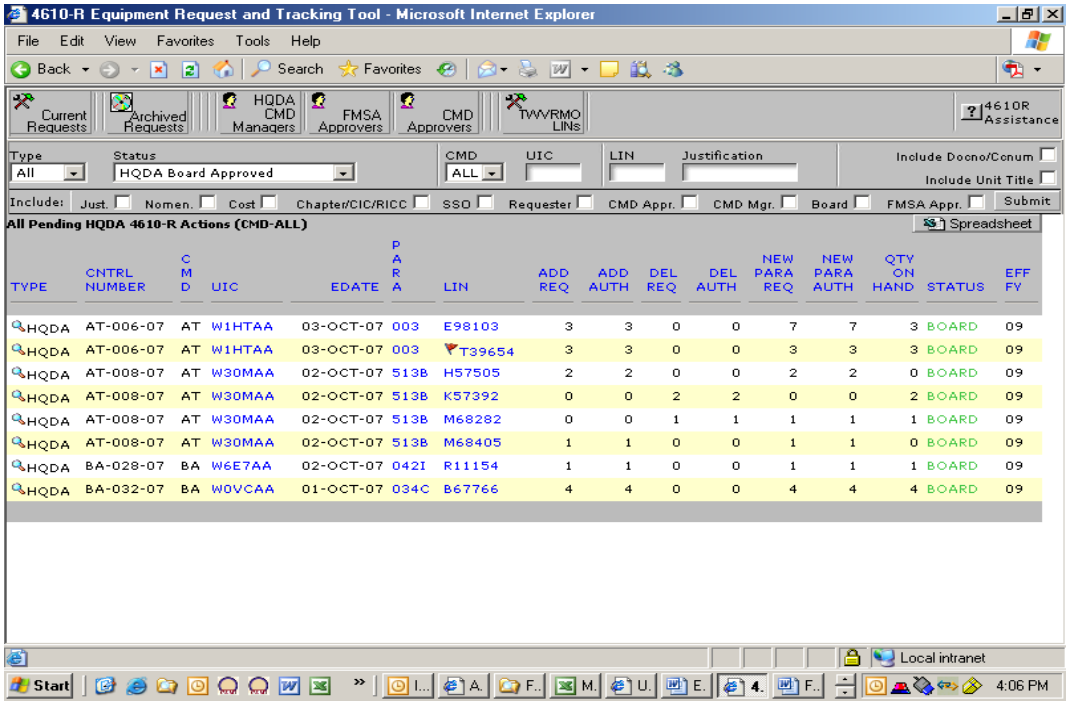
(d) For items HQDA Board Disapproved, click on magnifying glass by item disapproved, click on the Update button to make changes, click on the Update button to make changes, click on arrow at the Status Window and chose BOARD_DENIED; or for bulk disapprovals, enter UIC and/or LIN and click on Submit for list by UIC and/or LIN for LINs to be disapproved, enter Board Date (do not enter Effective FY), then chose Deny and click on Submit (be careful, if there are LINs that have been approved or deferred to not disapprove those)

(e) After all HQDA Board Disapproved have been recorded, click on Submit for a new listing of HQDA Board Locked for Review

(f) Enter Effective FY and Board Date, then chose Approve and click on Submit (be careful, if there are LINs that have been deferred, then also enter UIC and/or LIN for bulk approvals and click on Submit for list by UIC and/or LIN for LINs to be approved)

(g) For those items with a different FY, change FY as needed

(h) Status changes to HQDA Board Approved or HQDA Board Denied and EFF FY column shows the effective FY the LIN is to be placed on the TDA.



g. Equipment Survey Results and Bulk Equipment Transfers

(1) If an equipment survey has been performed or there is a bulk transfer of LINs from one UIC to another UIC (usually between Commands), then the Batch Upload process may be used.

(2) The process to use the Batch Upload option is as follows:

(a) A Microsoft Access or Microsoft Excel (if Excel, must be converted to Access before uploading) file is created with the following structure:

1. CNTRLNUMBER – control number (Command Control Number (CCNUM) prefix, the sequence number (three digits), and the current fiscal year suffix; for example TC-001-07 would be the first request submitted by TRADOC in fiscal year 2007)
2. DOCNO – document number (command code and UIC)
3. CCNUM – Command Control Number (i.e. 0108, must be four characters)
4. PARA – paragraph (i.e. 003 or 005B)
5. LIN – Line Item Number
6. LINUM_UPGRADE – Force Modernization Upgrade LIN (to replace deleted LIN) if an obsolete LIN is being deleted for a modern LIN, enter the modern LIN
7. ADD_REQ – quantity required to add (must be digits, not text)
8. ADD_AUTH – quantity authorized to add (must be digits, not text)
9. DEL_REQ – quantity required to delete (must be digits, not text)
10. DEL_AUTH – quantity authorized to delete (must be digits, not text)
11. QTY_ON_HAND_FOR_UIC – quantity on hand for UIC (must be digits, not text)
12. JUSTIFICATION – justification (up to 255 characters). For equipment surveys, start the justification with “Equipment Survey conducted on“ and other justification as necessary. For equipment transfers, start the justification with “Transfer from WxxxAA name of unit to WyyyAA name of unit” and other justification as necessary. For approved Concept Plans, start the justification with “Part of approved Concept Plan xxxxx” (title) and other justification as necessary.
13. REQUESTER_NAME – requester name (Army Knowledge Online name, i.e. john.doe)
14. REQUEST_DATE – requester date (day – month – year i.e. 01-APR-07)

15. CMD_APPR_NAME – command approver name (Army Knowledge Online name, i.e. mary.m.smith)

16. CMD_APPR_DATE – command approver date (day – month – year i.e. 01-APR-07)

17. CMD_APPROVER_NOTES – command approver notes (up to 200 characters)

(b) The Batch Upload file is sent to your USAFMSA documenter for review and uploading.

(c) Forces Command (FORSCOM) has a FORSCOM Equipment Survey Program that automates an equipment survey and will export the equipment survey results in the correct format. Contact US Army Forces Command, ATTN: AFOP-FDO, 1777 Hardee Avenue SW, Fort McPherson, GA 30330-1062 or telephone Mr. Royce Rhoades, DSN 367-6778, COM (404) 464-6778, e-mail royce.rhoades@forscom.army.mil.

(3) Equipment will be tagged as either HQDA or FMSA. If the LIN is tagged as HQDA, the Command Manager will review and approve or disapprove the request. If Command Manager approved, the LIN will be reviewed by the HQDA TDA Unit Equipment Review and Validation Board. If the LIN is tagged as FMSA, the documenter will review and approve or disapprove the request. LINs with the TWVRMO flag require the Tactical Wheeled Vehicle Justification Questionnaire (TWVJQ) be submitted to TWVRMO for review and recommendation. Click on the little red flag for a prompt to save the TWVRMO LIN TWVJQ Form. TWVRMO web site is http://www.transchool.eustis.army.mil/twvrmo

GLOSSARY

Acronyms are listed on pages GL-1 through GL-9
Terms/Definitions are listed on pages GL-11 through GL-13

Acronyms:

Abbreviation	Definition
AAALAC	American Association for Accreditation of Laboratory Animal Care
AAC	Acquisition Advice Code
ACN	Asset Control Number
ACSIE&FM	Assistant Chief of Staff for Installations Environment and Facility Management Environment and Facility Management
ACSIM	Army Chief of Staff for Installation Management
ACSLOG	Assistant Chief of Staff for Logistics
ACSRM	Assistant Chief of Staff for Resource Management
ACTEDS	Army Civilian Training, Education and Development System
ADA	Americans with Disabilities Act
ADAL	Addition or Alteration
AEFRP	Army Emergency First Responder Program
AFR	Air Force Regulation
AIA	American Institute of Architects
AIS	Automatic Information System
AIT	Automatic Information Technology
AKO	Army Knowledge Online
AM	Assemblage Management
AMC	Army Materiel Command
AMC/SG	Air Mobility Command/Surgeon General
AMDF	Army Master Data File
AMEDD	Army Medical Department
AMEDDC&S	Army Medical Department Center and School
AMSCO	Army Management Structure Code
ANSI	American National Standard Institute
AO	Approving Official
AOD	Administrative Officer of the Day
APC	Accounting Processing Code
APS	Army Pre-Position Stocks
AR	Army Regulation
ARC	Accounting Requirements Code
ARIMS	Army Record Information Management System
ARNG	Army National Guard
ARSAMS	Army Reserve Supply and Maintenance System
ASARDA	Assistant Secretary of the Army for Research, Development and Acquisition
ASD/HA	Assistant Secretary of Defense for Health Affairs
ASHE	American Society of Healthcare Engineers
ASIOE	Associated Support Items of Equipment
ASL	Authorized Stockage List
ASN	Allotment Serial Number
AT/FP	Anti-Terrorism / Force Protection
AWR	Air-Worthiness Release
AXOL	Access Online

Abbreviation	Definition
BDN	Build Directive Number
BMSO	Brigade Medical Supply Office
BO	Business Objects
BPA	Blanket Purchase Agreement
BSC	Balanced Score Card
BSL3	Bio-Safety Level 3 Facility
C, ES	Chief, Environmental Services
C.A.R.E	Customer Automation and Reporting Environment
CAD	Computer-Aided Design/Drawing
CADD	Computer-Aided Drafting and Design
CAIM	Customer Area Inventory Management
CAP	Council of American Pathologists (CAP)
CAPS-W	Commercial Accounting and Payment System Worldwide
CARS	Custom Army Reporting System
CATCODE	Category Code
CBRN	Chemical Biological Radiological and Nuclear
CBT	Computer Based Training
CCIR	Commander's Critical Information Requirement
CDR	Commander
CEEP	Capital Expense Equipment Program
CFA	Current File Area
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CIF	Central Issue Facility
CIIC	Controlled Inventory Item Code
CLRP	Command Logistics Review Program
CLRT	Command Logistics Review Team
CLS	Combat Lifesaver
CMMS	Computerized Maintenance Management System
CMR	Command Management Review
COB	Close of Business
COCOM	Combatant Command(er)
CONUS	Continental U. S.
COR	Contracting Officer's Representative
CPC	CBRN Pharmaceutical Countermeasures
CSDP	Command Supply Discipline Program
CSH	Combat Support Hospital
CT	Computer Tomography
CTA	Common Table of Allowances
DA	Department of the Army
DAAS	Defense Automatic Addressing System
DAB	Division and Below
DAPA	Distribution and Pricing Agreement
DBBS	Defense Blood Bank System
DBPA	Decentralized Blanket Purchase Agreements
DCAM	DMLSS Customer Assistance Module
DCDD	Directorate of Combat and Doctrine Development

Abbreviation	Definition
DCM	DMLSS Communications manager
DEA	Drug Enforcement Administration
DENCOM	Dental Command
DEPMEDS	Deployable Medical Systems
DFAR	DoD Federal Acquisition Regulation
DFARS	DoD Federal Acquisition Regulations Supplement
DFAS	Defense Finance and Accounting Service
DFAS-IN	Defense Finance and Accounting Service - Indianapolis Center
DFAS-SA	Defense Finance and Accounting Service - San Antonio
DHP	Defense Health Program
DIC	Document Identifier Code
DIN-PACS	Digital Imaging Network–Picture Archiving Communications System
DISC	Defense Industrial Supply Center
DLA	Defense Logistics Agency
DLAM	Defense Logistics Agency Manual
DLAR	Defense Logistics Agency Regulation
DLIS	Defense Logistics Information System
DMFO	Defense Medical Facilities Office
DMLSS	Defense Medical Logistics Standard Support
DMLSS-FM	DMLSS Facility Management Module
DMMC	Division Materiel Management Center
DMSB	Defense Medical Standardization Board
DMSO	Division Medical Supply Office
DoD	Department of Defense
DODAAC	Department of Defense Activity Address Code
DoDI	DoD Instruction
DOL	Directorate of Logistics
DOS	Days of Supply
DOT	Department of Transportation
DPW	Director of Public Works
DRMO	Defense Reutilization and Marketing Office
DS	Division Surgeon
DSN	Defense Switching Network
DSCP	Defense Supply Center Philadelphia
DSN	Defense Switching Network
DVA	Department of Veterans Affairs
DWCF	Defense Working Capital Fund
EAC	Echelons Above Corps
ECAT	Electronic Catalog
ECIP	Energy Conservation Investment Program
ECN	Equipment Control Number
ECP	Exposure Control Plan
ED	Emergency Division
EEMP	Excess Equipment Management Program
EMCS/UMCS	Energy and Utility Monitoring and Control System
ESMIS	Environmental Service Management Information System
EOQ	Economic Order Quantity
EOR	Element of Resources
EPA	Environmental Protection Agency

Abbreviation	Definition
EPR	Environmental Program Requirements
EPR-M	Environmental Program Requirements - USAMEDCOM
ERP	Enterprise Resource Planning
ES	Environmental Services
ESL	Estimated Storage Life
ESO	Environmental Science Officer
ESOC	Emergency Supply Operations Center
ESPC	Energy Savings Performance Contract
E&TM	Equipment and Technology Management
F&AO	Finance and Accounting Office
FAAST	Facility Assistance and Assessment Support Team
FAD	Financial Authorization Document
FAQ	Frequently Asked Questions
FAR	Federal Acquisition Regulation
FCI	Facility Condition Index
FDA	Food and Drug Administration
FEDLOG	Federal Logistics Record
FEDSTRIP	Federal Standard Requisitioning and Issue Procedures
FIA	Financial Inventory Accounting
FLCM	Facility Life Cycle Management
FM	Facilities Management, or, Field Manual (when followed by a number)
FM-ACE	Facility Management Applied and Continuing Education
FMB	Facility Management Branch
FMV	Fair Market Value
Fund Owner	
FORSCOM	U. S. Army Forces Command
FSC	Federal Supply Catalog / Federal Supply Class
FSM	Facility Sustainment Model
FSMC	Forward Support Medical Company
FSS	Federal Supply Schedules
FST	Forward Surgical Team
FTP	File Transfer Protocol
FY	Fiscal Year
GCSS-A	Global Combat Support System-Army
GFP	Government Furnished Property
GPC	Government Purchase Card
GSA	General Services Administration
GWOT	Global War on Terrorism
HA	Health Affairs
HAZMAT	Hazardous Materiel
HCA	Health Care Activity
HCP	Hazard Communication Program
HFPA	Health Facility Planning Agency
HM	Hazardous Materiel
HQIFS	Headquarters Integrated Facilities System
HTTPS	Hyper Text Transfer Protocol

Abbreviation	Definition
IAW	In Accordance With
IFS-M	Integrated Facilities System Mini/Micro
his	Indian Health Service
IM	Inventory Management
IM/IT	Information Management/ and Information Technology
IM/ITS	Information Management and Information Technology Systems
IMCOM	Installation Management Command
IMMSS	Integrated Modular Medical Support System
IMPAC	International Merchant Purchase Authorization Card
IMSA	Installation Medical Supply Activity
IPD	Issue Priority Designator
IPP	Installation Protection Program
IS	Information Systems
ISP	Installation Support Package
ISR	Installation Status Report
ISSA	Inter-Service Support Agreements
ITO	Installation Transportation Office
JC	Join Commission (Accreditation of Healthcare Organizations)
JDF	Joint Deployment Formulary
JER	Joint Ethics Regulation
JMAR	Joint Medical Asset Repository
LAN	Local Area Network
LIN	Line Item Number
LMC	Linen Management Committee
LO	Land Operations
LSU	Life Safety Upgrade
M&R	Maintenance & Repair
MACOM	Major Command (U. S. Army)
MC4	Medical Communications for Combat Casualty Care
MCA	Military Construction, Army
MCDM	Medical Chemical Biological Radiological and Nuclear (CBRN) Defense Materiel
MCFAS	Managed Care Forecasting and Analysis System
MCN	Management Control Number
MCO	Marine Corps Order
MCSC	Materiel Category Structure Code
M/DPQDR	Medical/Dental Product Quality Deficiency Report
MEDCASE	Medical Care Support Equipment
MEDCAT	Medical Catalog
MEDCEN	Medical Center
MEDCOM	U.S. Army Medical Command
MEDDAC	Medical Department Activity
MEDLOG	Medical Logistics
MEDLOG Bn	Medical Logistics Battalions
MEDSILS	Medical Services Information Logistics Systems
MEDSUP	Medical Supply
MEDSURG	Medical/Surgical
MEET	Mission Essential Equipment Training

Abbreviation	Definition
MEIS	Military Environmental Information Source
MER	Medical Equipment Repairer
MES	Medical Equipment Sets
MFR	Memorandum For Record
MFT	Materiel Fielding Team
MHS	Military Health System
MIDI	Military Item Disposition Instructions
MILCON	Military Construction
MILSBILLS	Military Standard Billing System
MILSTRIP	Military Standard Requisitioning and Issue Procedures
MIREP	Medical Instrument Recycling Program
MLMC	Medical Logistics Management Center
MLST	Medical Logistics Support Team
MMBP	Military Medical Benefits Property
MMI	Medical Materiel Information
MMQC	Medical Materiel Quality Control
MMR	Maintenance Management Report
MMS	Medical Materiel Sets
MNT	Maintenance
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MOV	Materiel Obligation Validation
MR/MC	Major Repairs/Minor Construction
MRMC	Medical Research and Materiel Command
MRO	Materiel Release Order
MSC	Major Subordinate Commands
MSDS	Materiel Safety Data Sheets
MSE	Mobile Subscriber Equipment
MSMC	Main Support Medical Company
MSO	Medical Supply Officer
MSPC	Medical Space Planning Criteria
MST	Medical Support Team
MTDA	Modified Table of Distribution and Allowances
MTF	Medical Treatment Facility
MTOE	Modified Table of Organization and Equipment
M/DPQDR	Medical/Dental Product Quality Deficiency Reports
NAC	National Agency Check
NATO	North Atlantic Treaty Organization
NAVMEDCOMINST	Naval Medical Command Instruction
NAVSUP PUB	Navy Supply Publication
NAVSUPINST	Navy Supply Instruction
NDC	National Drug Codes
NFPA	National Fire Protection Association
NGB	National Guard Bureau
NICP	National Inventory Control Point
NLT	Not Later Than
NNMC	National Naval Medical Center
NOSTRA	Naval Ophthalmic Support and Training Activity
NSN	National Stock Number

Abbreviation	Definition
O&M	Operations & Maintenance
OAP	Organizational Assistance Program
OCIE	Organizational Clothing and Individual Equipment
OCONUS	Outside Continental U. S.
OFAB	Optical Fabrication Advisory Board
OFE	Optical Fabrication Enterprise
OFL	Optical Fabrication Laboratories
OIP	Organizational Inspection Program
OMA	Operations and Maintenance, Army
OMB	Operations Management Bulletin
OMD	Operations and Maintenance, Defense
OPA	Other Procurement, Army
OPD	Other Procurement, Defense
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety & Health Administration
OST	Order and Shipping Time
OTR	Oracle Tech Refresh
OTSG	Office of the Surgeon General
P&D	Potency & date
PAD	Patient Administration Division
PARC	Principle Assistant Responsible for Contracting
PBO	Property Book Officer
PBT	Pyridostigmine Bromide Tablets
PBUSE	Property Book Unit Supply Enhancement
PDA	Personal Data Assistant
PDP	Predeployment Processing
PDREP	Product Data Reporting and Evaluation Program
PFD	Program for Design
PHS	Public Health Service
PM	Preventive Maintenance
PMBS	Precious Metals Bearing Scrap
PMC	Precious Metals Coordinator
PMed	Preventive Medicine
PMI	Patient Movement Items
PMITS	Patient Movement Item Tracking System
PMM	Precious Metals Monitor
PMO	Program Management Office
PMRP	Precious Metals Recovery Program
POC	Point of Contact
POU	Point of Use
PPP	Power Projection Platform
PR	Purchase Request
PRA	Property Record Administrative Adjustment
PROFIS	Professional Officer Filler Information System
PRV	Plant Replacement Value
PRweb	Purchase Request Web
PSP	Power Support Platform
PV	Prime Vendor

Abbreviation	Definition
QA	Quality Assurance
QC	Quality Control
RC	Reserve Component
RCHD	Reserve Component Hospital Decrement
RCM	Reliability Centered Maintenance
RDTE	Research Development Test and Evaluation
RIA	Regional Incentive Agreements
RIC	Routing Identifier Code
RFID	Radio Frequency Identification Devices
RMC	Regional Medical Command
RMW	Regulated Medical Waste
RO	Requisition Objective
ROD	Report of Discrepancy
RPPF	Radiation Protection Program Files
SAMS-1	Standard Army Maintenance System Level 1
SAMS-2	Standard Army Maintenance System Level 2
SAP	Systems Applications and Products
SAV	Staff Assistance Visit
SB	Supply Bulletin
SC	Supply Catalog
SCM	Supply Chain Management
SCP	Spill Contingency Plan
SCR	System Change Request
SECNAVINST	Secretary of the Navy Instruction
SF	Standard Form
SIMLM	Single Integrated Medical Logistics Manager
SKO	Sets, Kits, and Outfits
SLC	Shelf Life Code
SLEP	Shelf Life Extension Program
SMDA	Safe Medical Devices Act
SME	Subject Matter Expert
SOS	Source of Supply
SOW	Statement of Work
SRM	Sustainment, Restoration, and Modernization
SRP	Soldier Readiness Processing
SRTS	Spectacle Request Transmission System
SSA	Supply Support Activity
SWA	South West Asia
TAC	Transportation Account Code
TAMMIS	Theater Army Medical Management Information System
TAT	To Accompany Troops
TB	Technical Bulletin
TB MED	Technical Bulletin, Medical
TCAM	TAMMIS Customer Assistance Module
TDA	Table of Distribution and Allowances

Abbreviation	Definition
TDY	Temporary Duty
TEWLS	Theater Enterprise Wide Logistics System
TI	Technical Inspection
TM	Technical Manual
TMDE	Test, Measurement, and Diagnostic Equipment
TMIP	Theater Medical Information Program
TMOP	Tricare Mail Order Pharmacy
TMU	Table Maintenance Utility
TO&E	Table of Organization and Equipment
TRIMEDS	Tri-Service Medical Excess Distribution System
TRO	TriCare Regional Office
TSG	The Surgeon General
TSMP	Temperature Sensitive Medical Products
UA	Unit Assemblage
UAL	Unit Assembly Listing
UAMT	Unit Assemblage Management Tool
UBL	Unit Basic Load
UDP	Unit Deployment Packages
UDR	Universal Data Repository
UIC	Unit Identification Code
ULLS-G	Unit Level Logistics System Ground
ULLS-S4	Unit Level Logistics System – S4
UMC	Unspecified Minor Construction
USAR	U. S. Army Reserve
USARC	U. S. Reserve Command
USACHPPM	U.S. Army Center for Health Promotion and Preventive Medicine
USAFMSA	U.S. Army Force Management Support Agency
USAHFPA	U.S. Army Health Facility Planning Agency
USAMEDCOM	U.S. Army Medical Command
USAMITC	U.S. Army Medical Information Technology Center
USAMMA	U. S. Army Medical Materiel Agency
USAMMA-NMP	U. S. Army Medical Materiel Agency-National Maintenance Point
USAMMCE	U. S. Army Medical Materiel Center Europe
USAMMDA	U. S. Army Medical Materiel Development Activity
USAR	U. S. Army Reserve
USARC	U. S. Army Reserve Command
USAREUR	U. S. Army Europe
USARPAC	U. S. Army Pacific
USP	US Pharmacopeia
USPFO	U. S. Property and Fiscal Officer
VETCOM	Veterinary Command
VFA	Vanderweil Facility Advisors
WAWF	Wide Area Work Flow
WAWF-RA	Wide Area Work Flow-Receipts and Acceptance
WMD-CST	Weapons of Mass Destruction Civil Support Teams
WRAMC	Walter Reed Army Medical Center

Terms:

Term	Definition
Accountability	Obligation to keep records of property, documents, or funds, such as item identification data, gains, losses, dues-in, dues-out, and balances on hand or in use. (*AR 40-61*, *AR 710-2*, *AR 735-5*, *DA PAM 710-2-1*, *DA PAM 710-2-2*)
Accountable officer	Person officially appointed in writing to maintain a formal set of accounting records of property or funds. This person may or may not have physical possession of the property or funds. Two types of accountability most common to medical facilities or organizations are: a. Formal – Stock record accounting for supplies being held for issue from time of receipt until, issued, shipped or dropped from accountability. (*AR 40-61*, *AR 710-2*, *AR 735-5*, *DA PAM 710-2-1*, *DA PAM 710-2-2*). b. Property Book – Accounting for nonexpendable organization property upon receipt and until subsequently turned-in, used (consumed) for authorized purposes, or dropped from accountability. (*AR 40-61*, *AR 710-2*, *AR 735-5*, *DA PAM 710-2-1*, *DA PAM 710-2-2*).
Army Master Data File (AMDF)	An official source of supply management data used in medical logistics. The U.S. Army Materiel Command publishes it monthly.
Army Medical Command	An organization that has command over one or more MEDCENs, MEDDACs, or medical research activities. Includes U.S. Army Medical Command, U.S. Army Medical Research and Materiel Command, and 18th Medical Command.
Bulk (liquid) gases	A fixed, central system consisting of a main storage tank that pipes oxygen, ethylene oxide, or other gasses to patient care areas.
Capital expense equipment program	Equipment having a unit price less than current OPD threshold.
Command Surgeons	Senior Medical Corps officer who is part of the Division/Corps/Theater/MACOM special staff. Keeps the commander informed regarding medical aspects of operations.
Durable item	An item of Army property coded with an ARC of “D” in the AMDF or DoD Medical Catalog. Durable items do not require property book accountability. Durable items are identified with an ARC “D” in the AMDF or UDR. Commercial and fabricated items similar to items coded “D” in the AMDF or UDR are considered durable items.
Expendable	An item that is consumed or loses its identity in use. Expendable items are identified with an ARC of X in the AMDF or UDR.

Term	Definition
Gas analysis	A measurement of the percentage of the gas in a sample by volume using a battery-operated, portable, hand-held instrument.
Health Care Activity (HCA)	All TOE and TDA facilities that provide medical care and support. Includes hospitals, clinics, dental activities, veterinary activities, combat stress, preventive medicine, logistics, and evacuation.
Installation medical supply activity (IMSA)	In CONUS, the SSA for medical materiel for an installation or geographic area. In OCONUS, it is normally the primary SSA for medical materiel for a designated geographic area.
Leased Equipment	Leased equipment requires legal agreement and accountability. Files should contain authorization, lease agreement with applicable amendments, and receipt of turn-in/return documentation.
Loaned Equipment	Equipment provided “free of charge” while using vendors’ software applications and reagents in the medical arena. This includes vendor equipment furnished with established Blanket Purchase Agreements.
Major Subordinate Commands (MSC)	MSCs under USAMEDCOM; includes RMCs, CHPPM, VETCOM, DENCOM, AMEDDC&S, and USAMRMC.
Management level	An acceptable range of performance expressed with upper and lower control limits. Performance that is not within the acceptable range warrants management review.
Management objective	The point of measured performance that is generally attainable under normal operating conditions.
Medical Care Support Equipment (MEDCASE)	That equipment required in AMEDD TDA fixed health care activities that is authorized for acquisition through OPD and MED MILCON funding programs.
Medical materiel	Medical materiel includes nonexpendable, durable, and expendable supplies used in HCAs, medical research and laboratory facilities and other medical related institutions and units in the AMEDD.
Military Medical Benefits Property (MMBP)	Consists of equipment loaned from a treatment facility to authorized personnel when needed for the treatment of injury or disease.

Term	Definition
Performance measures	A selected indicator that is used as a barometer or gauge to compare actual performance against a management objective or the parameters of a management level.
Regulated Medical Items	Materiel identified in the AMDF or FEDLOG or UDR with an AAC A. Examples would be MES, patient-movement items, and ASIOE.
Regulated Medical Waste	Includes liquid or semi-liquid blood or other potentially infections materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potential infectious materials during handling; contaminated sharps; and pathological and microbiological waste containing flood or other potentially infectious materials.
Type I complaint	Initiated when materiel (including equipment items) is determined by use or test to be harmful or defective to the extent that its use has caused or may cause death, injury, or illness. Immediate action will be taken to report such items and suspend them from use.
Type II complaint	Initiated when medical materiel other than equipment is suspected of being harmful, defective, deteriorated, or otherwise unsuitable for use. Expeditious action will be taken to report these items and suspend them from use.
Type III complaint	Initiated when equipment is determined to be unsatisfactory because of malfunction, design, or defects (attributable to faulty materiel workmanship and/or quality inspection or performance). Does not necessarily require suspension of the item.

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